East Boro Housing Trust Limited

Weymouth Office

Inspection report

Unit 2a, 83 Lynch Lane, Weymouth, Dorset, DT4 9DN
Tel: 01305 750403
www.ebht.org.uk

Date of inspection visit: 21 and 25 September 2015
Date of publication: 13/11/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This announced inspection was the first inspection of this service since it registered with the Care Quality Commission in December 2014. The inspection visits took place on 21 and 25 September 2015 and we spoke with staff and professionals over the following two weeks.

Weymouth office provides personal care to people living in their own individual and shared flats in Weymouth and Dorchester. At the time of our inspection there were 29 people receiving support that included personal care from the service. Most of the people who used the service had a learning disability but the service also supported older people.

The service had a registered manager who was away on holiday at the time of our inspection. They had been the registered manager since the service registered with the Care Quality Commission. Their line manager who was the nominated individual for the provider was available throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, and relatives, told us they were happy with the care and support they received from the service. Some

Summary of findings

people did not use words to communicate and were not able to tell us about their experiences. We saw they were relaxed and happy with staff and that staff treated everyone with kindness and respect.

People received support that met their needs and reflected their preferences. Their opinions were sought and reflected in how they received care and how risks they faced were managed. Care was provided in line with the principles of the Mental Capacity Act 2005. This meant that people were supported to make as many decisions about their care as they could. When they were unable to make their own decisions these were made in a way that did not involve unnecessary restrictions.

People were protected from harm. They told, and showed us that they felt safe. Staff understood how to identify signs of abuse and knew what their responsibilities were in reporting it.

People were cared for by staff with the right skills and knowledge. Some staff had worked with people before they moved to the service and had transferred from the local authority. These staff felt supported in the changes this had involved. The staff felt they could approach their management and that they were involved in the development of the service.

The support people received was monitored to ensure that any quality issues were addressed.

People and their relatives were listened to and suggestions and complaints were received and acted upon appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People were at a reduced risk of harm and abuse because staff knew how to recognise and report abuse.

People's risks were assessed appropriately and care plans provided guidance on supporting people in ways that minimised risks and promoted independence.

People were supported by enough staff to meet their needs. Staff were recruited safely but the service had not made sure that all agency staff had been checked and trained appropriately.

People received their medicine safely. Medicines were administered and stored safely.

Is the service effective?

Good

People's care was delivered effectively. Staff and people were confident that the staff had the skills and knowledge they needed to meet people's needs.

Staff worked in partnership with health and social care professionals to ensure people's needs were met.

People were supported in line with the principles of the Mental Capacity Act 2005. Staff promoted people's ability to make decisions and acted in their best interests when necessary but this was not always recorded clearly.

People were supported to eat and drink safely and to have choice and involvement in meal planning.

Is the service caring?

Good

People received kind and compassionate care. Staff communicated with people in a friendly and warm manner that reflected their communication needs. People and relatives spoke highly of the staff.

People and their relatives were listened to and involved in making decisions about their care.

People were treated with dignity and respect and their privacy was protected.

Is the service responsive?

Good

People received a responsive service. They had care plans which provided staff with guidance on how to meet their needs and staff involved people in activities that reflected their preferences.

People and their families were listened to about their care. They were able to make suggestions or raise complaints and these were responded to appropriately.

Is the service well-led?

Good

The service was well led.

The management structure reflected the needs of the service and staff and health and social care professionals had confidence in this.

There were systems in place to check on and improve the quality of care people received.

Summary of findings

Staff understood their roles and felt able to seek support and guidance from their managers.

Weymouth Office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 21 and 25 September 2015 with calls taking place until the 7 October 2015. The inspection was announced because the service is small and we wanted to be certain there would be staff available. The inspection team was made up of two inspectors.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us about information that could affect people's care and the Provider Information Record (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we visited 14 people who received care from the service in their homes. We spoke with two relatives and seven members of staff. We observed care practices and looked at eight people's care records, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring checks.

We also spoke with a social care professional and two healthcare professionals who had worked with the service.

Good

Is the service safe?

Our findings

People were safe. Most people we met during our inspection did not use words consistently to communicate; they were relaxed in the company of staff and referred to them positively. One person told us, "I always feel safe." and relatives told us they were not concerned about people's safety. People were at a reduced risk of experiencing harm and abuse because staff understood how to recognise and report abuse. Staff explained that they had contact details for the agencies that have a role in responding to abuse allegations and would contact these agencies directly if it was not possible, or appropriate, to contact their managers. Training was provided in an online format which staff refreshed annually and staff received a copy of organisational policies that related to keeping people safe as part of their induction.

People were supported by staff who understood the risks they faced. Care plans included information about how to support people in a way that balanced people's independence whilst minimising risks. People had personalised risk assessments about a range of activities and situations such as spending time on their own, accessing kitchen equipment and support with mobility. People's views were taken into account and healthcare professionals had been involved to ensure that risk assessments and the associated care plans were appropriate. Incidents were reviewed and actions taken to ensure emerging risks were responded to. For example, a person hurt themselves whilst cooking and this had led to the development of a new risk assessment with guidance for staff.

There were sufficient staff to meet people's needs. There were vacant positions in one part of the service which meant that agency staff were used regularly. Staff told us that if they could not find full staff cover people might not get their entire allocation of staff but would share staff with someone else. This did not mean that people were not supported safely but sometimes reduced the flexibility of when they could do certain activities. In some cases the person did not lose these hours and they were 'banked' to provide individual support to meet their needs at another time.

When agency staff were used the agency usually provided regular care workers who had known the people over a long period of time. The service did not have documentation detailing the training and checks of these agency staff. We spoke with the registered manager about this and they showed us this had been rectified. This meant that the service protected people by being sure that the agency staff had been through necessary safety checks and training. New staff were recruited to the service safely and had the appropriate background checks, including references, a complete employment history and criminal records checks.

People received their medicines safely. Staff received training and were assessed as competent to administer medicines. A medicines check had been undertaken in June 2015 and had picked up errors. These errors had been analysed and measures had been put in place to reduce the risk of similar mistakes. Staff told us that these measures were working. We looked at the administration of seven people's medicines. The records were accurate and their medicines were stored safely.

Good

Is the service effective?

Our findings

People received care from supported staff that had the necessary knowledge and skills to meet their needs. People and relatives told us that the staff were good at their jobs. One person said, "They are all good." A relative told us, "All the staff I have met are switched on and communicate well." Staff received induction training before they started work and there was an on-going programme of training for staff to develop their skills. Staff told us their training enabled them to feel confident in their ability to carry out their roles. Training was delivered by a variety of methods including online and classroom based sessions with the addition of practical competence based assessment for manual handling and medicine administration. There was a system in place for ensuring staff were up to date with their refresher training and this was working effectively. Staff were able to develop professionally through access to Health and Social Care apprenticeships, and some were doing so at level two and three. The service had introduced the care certificate and the nominated individual was taking a lead role in working through this nationally recognised induction with new staff.

Staff told us they felt supported. One member of staff said, "I have felt supported… we are supported." Some of the staff team were employed by the provider when the local authority service provision for some of the people the service supports had transferred over. They told us that this had been a significant experience. One member of staff said, "It was a huge change." Another told us it was a "frightening" prospect. They told us that initially they had felt lost in their new roles but that support and guidance had been made available quickly and they now felt part of the provider organisation. One member of staff who had been through this process said, "It has been a change in role and responsibility… I am proud of our team." Staff had regular supervision sessions which covered professional development and practice issues. Training needs and how training had altered their working practice was also covered at every session. This helped staff to use their knowledge and skills to improve the care of people they worked with.

Some of the people who received a service did not have the mental capacity to make decisions about their care and where they lived. We spoke with the nominated individual about the impact of the supreme court ruling that had extended the definition of deprivation of liberty to include people who were under constant supervision in their own homes. The nominated individual had liaised with the local authority to identify people this applied to and were waiting for the local authority to apply to the court of protection.

Some people did not have capacity to make decisions about some parts of their care; records were not clear about what decisions people had been assessed as not having capacity to make. The Mental Capacity Act 2005 (MCA) provides a legal framework to ensure that decisions made for people, when they do not have capacity to make the decision themselves, are done in their best interests. Staff understood this principle and supported people to make choices for themselves whenever this was possible. Where people did not have capacity to make decisions staff provided care that reflected the principle that care should always be delivered in the least restrictive way possible. It was not always clear how decisions had been made and who had been involved. The nominated individual and registered manager told us that they were working in partnership with the local authority to review care plans, mental capacity and best interest decisions. They also told us that the contracts between people and the service were being reviewed so that they were in a format that people could understand. The MCA Code of practice highlights the importance of communicating in ways that support people to understand decisions.

People were supported to eat and drink safely in line with their assessed needs. Where there were risks of choking staff understood these risks and were following guidance from speech and language therapists. Staff were working to reflect individual choice and balance safety when people chose not to follow guidance designed to keep them safe. People planned their meals and shopped for food with support individually or communally depending on their living arrangements and assessed needs. Staff had a good understanding of people's preferences and offered choice appropriately. One person told us the food the staff prepared for them was "always good".

People had access to healthcare professionals and were supported to take a lead in these relationships. One person showed us they had an appointment for a blood test booked and another person had their regular chiropody appointment recorded for them in their room. People, with learning disabilities, took their health book with them to

Good

Is the service effective?

appointments. The health books had been designed for people with learning disabilities to take a more active role in their healthcare and included plain English and pictures to support understanding. People had regular input from appropriate professionals and referrals had been made appropriately. Healthcare professionals told us if staff needed specialist advice they would ask for it and that they followed their recommendations. People's relatives told us staff listened to concerns about people's health and acted upon these.

Good

Is the service caring?

Our findings

People had positive warm relationships with staff. They told us they were treated with kindness and compassion. One person said, “They are lovely.” Another person said the staff were kind when they helped them. Staff spoke with affection and respect about people they supported and we observed that all interactions were personal and meaningful. For example, staff communicated kindness with touch alongside simple sentences with a person who did not use words to communicate. Staff took time to build relationships with people in an individual way referring to people’s interests or shared experiences during day to day communication. Some staff and people knew each other well because they had both moved from the person’s previous care setting. These relationships were valued by people and relatives who told us that familiar faces were important to their relatives.

Staff spoke confidently about people’s likes and dislikes and were aware of people’s histories. They used their knowledge of individual’s needs, preferences and experiences to help people make choices and take control whenever possible. For example, a member of staff supported a person to share their experience of living in their new home by showing us their room and sharing activities they enjoyed. The staff member assisted with communication because the person did not use words to communicate but supported them to take the lead throughout.

People made choices about day to day activities such as what they wanted to eat and drink. They were also able to make choices that might be deemed unwise by others when they had capacity to do so. When appropriate these choices were reflected in people’s care plans supported by specific risk assessments. Relatives told us they also felt listened to and were kept informed and involved in their relatives lives.

Care was provided in a way that protected people’s privacy and promoted dignity. This was apparent in group living environments and individual’s homes. Staff sought permission before undertaking tasks and checked that the actions they took were satisfactory to the person. People’s personal care was managed by staff discretely and staff did not talk about people’s care needs in front of other people. When staff shared information with us about people’s care they did this in a way that both included and deferred to the person.

Good

Is the service responsive?

Our findings

People's care was planned and delivered in a way that met their needs and preferences. People told us that the care they got was right for them. One person said, "The carers help me with what I need." Another person said, "They always do what they are meant to do." A relative told us that care was right for their loved one. They told us that the service had helped them to do more than they had before. People's care plans gave staff information about the person, including their preferences, likes and dislikes and the level of support needed. These included personalised information relating to aspects of care such as communication, mobility and specific health needs Staff told us that these care plans were useful and reflected care needs accurately. One member of staff said, "They are our bible – everything is there." People were involved in shaping their care plans and we saw that their views were reflected. They were not, however, presented in a format that people could understand. For example people who could not read did not have care plans containing pictures or audio that would support their understanding.

People's care needs were reviewed appropriately. All staff were involved in this and left messages for senior staff if they identified that a change might be needed. Relatives told us they were kept informed of changes and they were involved in decisions when this was appropriate. When people's needs changed their care plans were reviewed to reflect this and the information shared with staff through formal and informal methods. Staff told us that communication books were used effectively to ensure they were up to date with any changes. This meant that staff felt confident they were aware of people's current needs.

People were involved in activities that reflected their preferences. One relative told us that their relative had a lot to do and this suited their sociable nature. Staff commented that it was positive to be able reflect individual likes through one to one funding. They described how a group of people liked living together but one liked beer and snooker and the others liked a glass of wine. They were able to go out and support people to enjoy the activities that suited them. People's care was commissioned in a way that meant in some of the places people were living in the service could use support hours flexibly; hours could be saved so that staff could support people in ways their regular staff allocation could not. This enabled people to do things like stay out late if they went to a show or have long days out if they wanted to go somewhere that required a journey. This was not the funding agreement for all the people who used the service.

The provider had a complaints procedure and staff all received a copy of this as part of their induction. Care plans identified whether people had received a copy of this procedure or whether someone else acted as their advocate in ensuring their rights were protected. The registered manager and nominated individual dealt with concerns and complaints promptly and these were seen as an opportunity to learn. Staff understood the complaints policy and had supported a person to make their complaints known to the nominated individual. Whilst the complaints policy was not available in a variety of formats, the importance of ensuring people using the service complained was made explicit in the staff handbook. The person's complaints had been investigated in detail and they had been spoken with at all stages to ensure they understood the process and the outcome.

Feedback was sought from people, relative and professionals about the service. People had been supported to comment on all aspects of their care as part of annual feedback sought by the provider. People were happy with their care and support and where any difficulties were highlighted these had been addressed in a timely manner with people.

Good

Is the service well-led?

Our findings

Staff felt involved in the development of the service because they were able to approach the management team and felt listened to when they did this. Staff, who had joined the provider from the local authority when people's care provision had transferred from the local authority to the provider, told us they felt part of the provider organisation. They were proud of the transition they had made and that they understood their new roles and responsibilities. This pride was reflected by the service's management team who acknowledged the change staff had gone through and identified the progress they had made. They told us that teams had worked hard to assimilate to each other. This had been successful and staff described shared values. They spoke about providing the best support they could for people and highlighted the importance of personalised care and support.

The management structure had developed to reflect the needs of the service and staff team. The registered manager and their line manager had kept this structure under review. Staff were all aware of the people in the management team who had responsibility for their supervision and support. Professionals and staff had confidence in the management of the service. One member of staff referred to the management team saying, "They are very good… Always there." A professional said, "They know what needs to be done." All staff felt they could raise issues of concern and told us these were discussed and addressed either individually or in staff meetings.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. Quality checks and reviews were undertaken monthly by senior staff and these led to action being taken when necessary. Record keeping had been reviewed and this had led to changes in an individual's support plan and closer supervision of staff recording by senior staff. The actions were then checked during the following review. A review of the administration of medicines had identified some minor shortfalls in record keeping when people declined their medicines. This was followed up with staff at a team meeting where good practice in medicine administration was highlighted and discussed. These processes ensured that improvement actions were understood by all the staff working with people.

Health and safety within the service was reviewed monthly. There were processes in place for reporting accidents and incidents and these were monitored as they occurred to ensure risk management measures were put in place when necessary.

Communication with staff reflected the way the service was delivered. Staff meetings were planned to enable as many staff as possible to attend and important information was also shared in handovers, by phone and email. Professionals who worked in partnership with the service identified that communication via the office was good and they were able to get information and set up meetings when necessary.