DHR Support Services Ltd

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## Inspection report

24 Chailey Avenue
Enfield
Middlesex
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19 October 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 |

# Summary of findings

## Overall summary

We carried out this inspection on 19 October 2017. This inspection was announced and the provider was given 48 hours' notice as the location provides a domiciliary care service and we needed to ensure that the registered manager would be available to support us with the inspection process. This was the provider's first inspection since the service had registered with the Care Quality Commission (CQC) on 26 May 2016.

DHR Support Service Ltd is a domiciliary care service providing personal care and support to people living in their own homes. At the time of this inspection the service was providing care and support to three people with autism and learning disabilities. The provider's future plans were to provide care and support within a supported living setting.

The service had a registered manager. 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.

One relative told us their relative received safe care and support. A safeguarding vulnerable adults policy was available and accessible by all staff which provided guidance on how to recognise and report abuse. Care staff confirmed that they had received training in safeguarding adults and demonstrated a clear understanding of the different types of abuse and the actions they would take to report any concerns.

Risk assessments in place identified people's individual risks, the impact on the person and what was needed to reduce or mitigate the likelihood of the risk occurring. Risk assessments were discussed, reviewed and updated by the staff team on a monthly basis.

Care staff supported people with medicines where this was an identified need. For two people receiving support, medicine support was managed in partnership with involved family members. Records confirmed that medicines were managed safely and effectively and were administered by staff who had been trained and assessed as competent to do so.

Records gave assurance that safe recruitment systems were in place to ensure that only care staff suitable to work with vulnerable adults were employed.

Care staff told us and records confirmed that they had all received a comprehensive induction when they first began their employment with the company. Following this they had all received training in a variety of topics as part of an on-going training programme.

Care staff confirmed that they were supported positively through regular supervision and team meetings. Care staff were yet to receive an annual appraisal as they had not completed a full year of employment.

The registered manager and care staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA) and the importance of ensuring people have maximum choice and control of their lives and that they are supported in the least restrictive way possible. Staff also understood the importance of always obtaining people's consent when supporting them with their care and support. However, although one relative confirmed that they had consented to the care and support that their relative received, care plans had not been signed to confirm that people or their relatives had consented to the care and support that they received.

Care plans were person centred, detailed and reflected the care and support needs of the person. Care plans were reviewed with the involvement of the person, relatives and the staff team on a regular basis and were updated accordingly.

People were supported with their healthcare needs where this support was an assessed need. We saw records detailing visits made to a variety of health care professionals, the reason for the visits, the outcome of the visits and any actions that needed to be taken post visit.

All staff knew the people they cared for and were very clear about the level of support each person required but also ensuring that each person maintained their own independence as far as practicably possible.

The provider had not received any complaints since they had begun providing a service. A complaints policy was available and accessible in an easy read format so that people and relatives were provided with guidance on how to raise a complaint. One relative told us that they did not have any complaints but knew who to speak with if they had any issues or concerns to raise.

The provider had a number of systems and processes in place to monitor and check the quality of care that was delivered. Where concerns were identified these were addressed so that subsequent learning could take place and improvements made to the delivery of service.

## 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

The service was safe. Staff demonstrated a good level of understanding of safeguarding adults and the actions they would take if they had any safeguarding concerns.

Safe medicine systems were in place to ensure people received their medicines appropriately and on time.

Care plans contained detailed risk assessments which identified people's risks associated with their care and support needs and how these were to be managed.

Robust recruitment practises were adhered to ensuring that only staff who were assessed as safe to work with vulnerable people were recruited.

### Is the service effective?

Good

The service was effective. Staff were provided with a comprehensive induction followed by regular training and supervision which enabled them to carry out their role effectively.

All staff understood the key principles of the MCA and followed them when supporting people with their care and support needs. However, care plans were not always signed by people and/or their relatives to confirm that they had consented to the care and support that they received.

People were supported accordingly with their healthcare needs where this was an assessed need.

### Is the service caring?

Good

The service was caring. Care staff knew the people they supported very well and were clear about each of their individual needs and requirements.

One relative confirmed that care staff were respectful and treated their relative with dignity.

Care staff knew and understood what was meant by person

centred care. They also clearly explained how they supported people to maintain their independence.

Care staff demonstrated how they were to ensure people from different backgrounds, cultures and religions were to be supported according to their needs and beliefs.

## Is the service responsive?

Good

The service was responsive. Care plans were detailed and contained person centred information so that appropriate care and support could be delivered.

Care plans were reviewed regularly in partnership with the person, their relative and the care staff team.

The registered manager ensured that people's needs were appropriately assessed before care and support was planned so that the service could be assured that the service would be able to meet the needs of the person.

An easy read version of the complaints policy was available so that people and relatives knew how to complain when and if they needed to.

## Is the service well-led?

Good

The service was well-led. A variety of systems were in place to monitor and check the quality of service being delivered.

The registered manager was open and transparent throughout the inspection process and was open to learning and making improvements to ensure the delivery of good quality care.

One relative and care staff members confirmed that the manager was always available and approachable.

# DHR Support Services Ltd

**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 checked 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 19 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector.

Prior to the inspection we reviewed relevant information about the provider which included the Provider Information Return (PIR). A PIR 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 the inspection we spoke to the registered manager and one care staff member. Following the inspection we spoke to one relative and a further two care staff members.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at three people's care plans and risk assessments.

We reviewed three staff files. We also looked at other documents such as medicines records, policies and procedures and quality assurance records.

Good

# Is the service safe?

## Our findings

Some people receiving a service from DHR Support Service Ltd were unable to understand and respond to or did not want to answer some of the questions that we asked them about whether they felt safe with the care staff that supported them. This was either due to the communication difficulties they encountered due to their disabilities or that they had expressed a wish not to speak with us. We were able to speak with one relative who told us, "At the beginning it was a bit challenging as [name of person] did not know the staff but now [person] does feel safe, yeah."

Staff had received safeguarding training as part of their induction and were able to describe the different types of abuse people could face. They were also able to clearly state the actions that they would take if they saw signs of or suspected abuse to be taking place. One staff member explained, "I am always checking for bruises or scratches. We also get a handover from the family after the person comes home from an outing. We have procedures which we follow which include informing the manager." A second staff member told us, "I would report my concerns to the manager. You can't just sit down and keep quiet about it. Abuse is zero tolerance."

Care staff also confirmed that they knew what the term 'whistleblowing' meant and would raise any concerns to the registered manager with the confidence that these would be addressed immediately and appropriately. Care staff also cited external agencies such as the CQC and police, who they could contact if appropriate action had not been taken by the provider.

Each person had a care plan which included comprehensive risk assessments that had identified each person's individualised risks associated with their care and support needs. Each person had a mental health risk management plan as well as risk assessments which covered any other specific area where risk mitigation guidance was required. Risks identified included self-harm, management of epileptic seizures, smoking, use of wheelchair and damage to property. Each risk assessment detailed the risk, the impact it had on the person and the strategies to be used to minimise or mitigate the likelihood of harm occurring. As part of the care plan review, risk assessments were reviewed on a monthly basis in partnership with the person, their relative and the staff team involved in the delivery of care and support. All care staff involved in each package of care were also required to sign the risk assessments confirming that they had read and understood the content.

People were supported with the administration and management of their medicines where this was an identified need. Medicines were administered by staff who had been trained and assessed as competent to do so safely. Medicine Administration Records (MAR) were complete and confirmed that people had been given their medicines as prescribed. For some people, medicine administration and management was carried out in partnership with family and relatives involved in the person's care and support. One relative confirmed that care staff always recorded the medicines that had been administered in the care folder present at the person's home.

However, we found that care plans did not always detail the support people required with medicine

administration. In addition, where people were non-compliant with their medicines, there was no information recorded on how this was being managed. We highlighted this to the registered manager who clearly explained the steps that had been taken to ensure any concerns around non-compliance with medicine were being addressed with the relevant professionals but acknowledged that this had not been recorded within the care plan. The registered manager confirmed he would address this following the inspection.

One relative told us and care staff also confirmed that each person had a team of care staff who regularly attended to their needs. The registered manager explained that rotas were set permanently with care staff allocated set shifts which ensured that people received care and support from regular care staff. One relative told us, "We have a regular team of carers. We need to as the carers need to know the needs of [relative]. I can tell when [relative] is not happy." No concerns were noted in relation to lateness and missed visits.

The provider had robust processes in place to ensure that all staff recruited underwent a number of checks to ensure their suitability to work with vulnerable adults. Staff files included completed application forms and records of interview. The provider had also obtained appropriate references for staff and carried out checks with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records confirmed that staff members were entitled to work in the UK.

We saw comprehensive records had been completed for every accident or incident that had occurred. All records of incidents were when people who had suffered an epileptic seizure. No accidents had occurred to date. Records showed the detail of the incident and the actions taken to ensure people were kept safe and free from harm. All incidents were monitored by the registered manager and analysed on a monthly basis as part of the person's care plan review.

Good

# Is the service effective?

## Our findings

We were unable to obtain much feedback from people or their relatives in relation to whether they felt that whether care staff that supported them were adequately trained to deliver effective care and support. One relative did comment, "At the beginning when they [provider] started it was a bit difficult as I had to go through everything with the care staff but now staff are fine. We observed them [care staff] and the family spent a lot of time training them as [person] has specific needs."

Care staff told us that they had received an induction before they started work and following this had received training in a variety of topics including moving and handling, medicine administration, safeguarding, epilepsy and health and safety. The registered manager confirmed that all staff were required to undertake the care certificate as part of their development. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

Records contained within staff files also confirmed that staff had participated in a number of training sessions and were required to complete a questionnaire following the training which assessed their knowledge and competency in the specific subject. Prior to commencing work all newly appointed care staff were required to complete a number of shadow shifts with an experienced member of staff so that they could gain experience as well as get to know the people they would be supporting. One staff member told us, "He [registered manager] cares about staff. Training is his main thing. He will never let staff work without receiving any training." Another staff member stated, "I did Makaton training, care certificate, induction and shadowing."

Care staff confirmed that they felt appropriately supported by the registered manager through a variety of methods included regular supervision. Staff supervision records recorded discussions around boundaries, training, customer feedback and safeguarding. Feedback from care staff included, "I receive regular supervision every two months. We talk about how I am feeling, my skills, how to improve and any concerns" and, "We talk about health and safety of clients, confidentiality. They are helpful and it is very good to refresh our memory." There were no appraisals available for any of the care staff as none of them had completed one year of their employment. The registered manager confirmed that appraisals were scheduled to take place in December 2017.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. The service provides personal care to people living in their own homes or within a supported living facility. People receiving personal care services were not subject to orders made by the Court of Protection.

The registered manager and care staff demonstrated a clear understanding of the MCA and its key principles

and how this was to be implemented through the care and support that they provided to people. The registered manager had completed mental capacity assessments for each person that they supported which covered people's level of capacity and recorded specific areas and decisions where people required support such as medicine administration. We asked staff about their understanding of the MCA. Responses we received included, "We understand that sometimes a person may not have capacity and we discuss this in team meetings. We always make sure though that we give people choice. We observe signs and symptoms to tell us when they are not happy or their body language and give them options as much as we can" and, "It's about how much information a person can understand and retain to make a decision. People sometimes can't assess dangers around them so as a carer I would assess the situation and then make a decision in their best interest."

However, we noted that care plans had not been signed by people or their relatives confirming that they had consented to the care and support that they or their relative received. One relative we spoke with confirmed that they had consented to the care and support that had been planned for their relative. We brought this to the attention of the registered manager who told us that the copy of the care plan held at people's homes had been signed. The registered manager confirmed he would ensure that a signed copy of the care plan was made available at the office.

People were supported to access a variety of health care services where this was an identified need. Most people had family and relatives to support them but where assistance was required we saw that the service had recorded details of the professional visit that had taken place which included visits from a social worker, dentist, dietician and neurologist, the outcome of the visit and any actions that were required to be taken post visit.

Most people receiving a package of care from the service did not require support with their meals or meal preparations as the person's family or relative were available to provide this support. Where care staff were required to provide this support, care plans detailed the level of support required, meal preferences and people's likes and dislikes.

Good

# Is the service caring?

## Our findings

One relative, when asked if they found care staff to be caring responded by saying, "Care staff have a caring approach and I am happy with them [care staff]."

We were unable to observe any interactions between people and care staff as we were unable to visit people in their own home. This was due to some people refusing to be visited as well as some people's inability to communicate their feelings and thoughts due to the level of their learning disability. However, care staff demonstrated a caring and respectful approach when talking about the people that they supported.

One relative confirmed that staff were kind and supported their relative with dignity and respect. Care staff attitudes towards people were professional and respectful. One care staff explained how they ensured people's dignity and respect was maintained at all times and said, "I always make sure the door is closed and I always explain what I am doing." Another care staff explained, "I always respect people's choices and decisions and give them privacy where they require."

Care staff understood that the care and support that they provided was not to be provided in a way which disabled people but was to be delivered in such a way that promoted people's independence. Care staff understanding and examples of maintaining people's independence included, "[Name of person] will ask me to call someone on their behalf but I will encourage [person] to come to the phone and make the call themselves" and "It is up to the service user. I give them space to let them do what they want but also help them when they need."

Care plans included tools and communication methods that encouraged people to be fully involved in the care and support that they received. Care staff had also received training in specific communication techniques which enabled them to communicate with people. Communication methods used by care staff included Picture Exchange Communication System (PECS) as well as easy read pictorial documents. Care plans also contained social stories for specific areas of care which care staff could use with the person as a tool to explain a particular situation. One example we saw was a social story for waiting and changes. This included pictorial guidance to support the person to manage an identified situation.

Care staff understood that each person was individual in relation to their cultural, religious or sexual beliefs and that care and support should be delivered respecting people's beliefs and wishes. Comments from care staff included, "People beliefs are their own choice and I respect that" and "I have worked with different people from different backgrounds. You have to respect the choices they make."

Good

# Is the service responsive?

## Our findings

Records confirmed that people received consistent and personalised care from a regular team of care staff. One relative confirmed this and care staff also explained that they were allocated to support the same person on a regular basis.

Each person had a person centred care plan which detailed the care and support that they required, how they wished for this to be delivered, their likes and dislikes, hobbies and leisure activities. We spoke with care staff about the care plans and we were told that the care plans were detailed and helpful and gave them information about the person enabling them to provide care and support which was responsive to their needs. One care staff said, "Care plans are good and useful to read, your knowledge increases." Care plans were reviewed on a monthly basis through a monthly care staff meeting held for each person within their own home. These meetings involved the person, their relative and the care staff team supporting the person. Feedback from the person or their relatives was incorporated into the reviews and care plans were updated accordingly.

One person's care plan contained an informative section on how staff would be successful in supporting the person in relation to their autism. The section detailed specific things care staff needed to know and do. One example included in the care plan stated, "Sometimes I find it difficult to explain to my staff what I want so I tend to communicate via behaviour that I have learnt long time ago. If I want to communicate something I may sit on the ground in front of the garden gate. This means I want to go for a drive."

In addition to the care plan, each person also had a behaviour support plan in place which looked at people's behaviours and then provided different strategies for care staff on how to manage those behaviours. The support plan looked at four different stages of people's behaviours and included primary preventative strategies when calm, secondary preventative strategies when becoming unsettled, tertiary preventative strategies when behaviour has become very unsettled and quaternary strategies when behaviour was calmer and rational. At each stage the plan gave guidance to staff on how to provide proactive support, active support, reactive intervention and proactive support – post crisis intervention.

Some people had detailed activity plans which formed part of their care plan. This was because during school holidays some people received an increased package of care from the service due to their place of education or day centre being closed. The provider had planned with the person and their relative a number of activities that care staff would support the person to participate in during that time.

We were told by the registered manager and one relative that each person had a folder at their home which contained a copy of their care plan, behaviour support plan and risk assessments. A daily recording book was also available where care staff were required to make notes of their observations, activities people had participated in, interactions and where appropriate if the person had received their meal and/or medicines. These notes provided current and detailed information to staff who were about to begin their shift, about the person and how their day had been and where required any follow up actions that needed to be addressed. This also enabled to staff to respond to people according to their mood and temperament as

observed.

The service had not received any complaints since they had begun providing a service. However, appropriate systems were in place and available to allow the service to effectively record, investigate, respond and learn from any complaints that they may receive in the future. The complaints policy was available in pictorial and easy read formats so that people would be able to understand how to complain if they so wished. One relative confirmed that they knew who to speak with if they had any concerns or complaints. The relatives told us, "If I have any problems I can call him [registered manager] at any time. I have not had the need to complain."

Good

# Is the service well-led?

## Our findings

One relative stated that they knew the manager and found him to be approachable. Care staff told us that the manager was good and supportive. Comments from care staff included, "He is a good manager, very good" and "He is a very good manager. Always approachable and available."

Care staff told us that they felt appropriately supported in their role through supervisions and team meetings. The registered manager told us and records confirmed that monthly team meetings were organised in partnership with people, their relatives and the care staff team, where each person's care and support package was reviewed as part of the team meeting. Topics discussed included the person's general well-being, incidents, mental capacity, health and safety and risk assessments. Care staff felt encouraged and enabled to contribute to these meetings and felt that the registered manager did listen and took on board their comments. One care staff told us, "We share experiences. He [registered manager] promotes us to talk in the group."

The registered manager had a number of systems and processes in place which enabled the service to monitor and check the quality of care services being provided. The registered manager completed monthly audits of each package of care that they were delivering and checks included medicines management, whether staff arrived on time, any complaints and whether the person was happy. The registered manager told us that as part of the monthly team meetings the outcome of audits were also discussed so that all care staff could develop an understanding of the process as well as be aware of any issues that were identified so that improvements could be made and learning could take place.

In addition the registered manager also asked people to complete monthly customer feedback forms. Care staff supported people with the completion of these forms where support was required and where people were unable to complete, the survey was completed by a relative. No concerns had been noted on the feedback forms that we looked at. The provider, as yet, had not carried out an annual stakeholder questionnaire exercise but had plans to do this over the forthcoming months.

The provider had a variety of policies and procedures in place which supported and guided staff on how care and support should be delivered safely and effectively. The registered manager had ensured that each care staff had read each policy which they had signed to confirm that they had read and understood.

Throughout the inspection process the registered manager demonstrated openness and transparency when asked for a variety of documents and information to enable the inspection process to assess whether the provider was meeting the minimum required standard as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where gaps were identified the registered manager accepted what we found and made immediate improvements where required.