Arundel Domiciliary Care Services Limited

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Inspection report

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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

Summary of findings

Overall summary

Arundel Domiciliary Care Services Limited is registered to provide personal care to people living with a learning disability and other complex needs, including autism and mental health. The service model is based on supported living with people receiving personal care and support from staff employed by the provider. People have their own service user/tenancy agreements. The service supports people across locations in East and West Sussex and Surrey.

At our last inspection in September 2016 we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People felt safe and received care and support from staff who understood and managed their risks appropriately. Lessons were learned and improvements made when things went wrong. Staffing levels were sufficient to meet people's needs and new staff had checks made on their suitability to work in a care setting. Medicines were managed safely. People were encouraged to be independent by participating in housekeeping duties such as laundry or cooking and keeping their rooms clean.

Technology was used to aid people's communication. Staff completed a range of training to meet people's care and support needs and attended supervision meetings with their line managers. People had sufficient to eat and drink and were encouraged with healthy diets and lifestyles. They had access to a range of healthcare professionals and services. People had personalised their rooms and had access to communal areas. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported by kind and caring staff and positive relationships had been developed. People were involved in all aspects of their care and were encouraged to make decisions and choices. They were treated with dignity and respect.

Care plans provided detailed information about people and guidance to staff. Positive behaviour support was used by staff to manage or prevent any incidents of challenging behaviour. Communication systems had been developed that were personalised and effective. People's diverse needs were catered for. People were involved in a range of activities, the majority of which were out in the community. Planners were organised to enable people to choose what they would like to do in line with their interests. Complaints policies were accessible and easy for people to understand.

Staff felt supported by their managers and spoke positively about working for the organisation. They were clear about their roles and responsibilities and feedback from a staff survey was positive. People and relatives were asked for their comments about the service and results were favourable. Audits were effective in monitoring and measuring the service and in driving continuous improvement.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

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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 was a comprehensive, announced inspection which took place between 31 May 2018 and 7 June 2018. We gave the service 48 hours' notice of the first day of our inspection visit because the locations provide a domiciliary care service for younger adults who are often out during the day. We needed to be sure they would be in. The inspection team consisted of four inspectors who visited people in four different locations which were staffed by this provider.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. Due to concerns in relation to a specific event that had occurred at one of the locations, and other issues reported to us in relation to the management of risks, the date of this inspection was brought forward. For this reason, a request for the provider to complete a Provider Information Return was not sent by the Commission. A Provider Information Return is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people at one location and completed observations of four other people over three other locations. Some people were unable to communicate with us or would have found it too distressing. We spoke with the nominated individual of the provider, four team leaders, who were responsible for the day-to-day management at each location and four support staff. We spent time

observing the care and support people received.

We reviewed a range of records about people's care and how each location was managed. These included six care plans and people's risk assessments. We reviewed records relating to medicines, staff training, support and employment records, audits, minutes of meetings, menus, policies and procedures, complaints and other records relating to the management of the service.

Good

Is the service safe?

Our findings

We asked people whether they felt safe where they lived. One person said, "Members of staff help sort out problems. Staff are very understanding with our disabilities. They understand that just because we have a disability we shouldn't be treated any differently. It can be difficult with the other people living here. Staff try to sort it out the best they can. Staff speak to me nicely. They take care of everything they can and I feel safe".

Lessons were learned and improvements made when things went wrong. We discussed safeguarding issues and incidents that had occurred at various locations where staff supported people. For example, staff members had been suspended and subsequently dismissed where serious incidents had occurred and abuse had been identified and investigated. The managers shared lessons learned with staff and keeping people safe was discussed and reflected upon at staff supervisions. Staff told us they were supported by managers when incidents occurred. Staff were clear about their responsibilities for honest and open communication in line with the requirements under Duty of Candour. Staff completed training in safeguarding which was refreshed every two years.

People's risks were identified, assessed and managed appropriately. Care plans showed how people's risks had been assessed and provided detailed information and guidance for staff. For example, one person, who smoked cigarettes on a regular basis, had a risk assessment that informed staff what was needed to ensure the person's risks relating to smoking were managed safely. Safe systems of working were identified and put into practice. People's independence was encouraged. One staff member explained, "People have risk assessments in place for when they do activities. We do our best to make things happen for people. I thought it might be a good idea for [named person] to meet people and go out on his own, so we contacted a local organisation that connects people with learning disabilities through social events. Now we drop him off and he can go to some of their nights at the pub on his own but stay safe. People's risks were managed in a way that supported any health issues they had, whilst enabling them to participate in things they enjoyed.

People had their own tenancy agreements at different locations. The properties that people lived in were managed by landlords or a housing charity. The provider was not responsible for the upkeep of the premises, but retained a duty to ensure people were not put at risk because of unsafe premises.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. Staffing levels were based on people's support needs and were flexible. For example, if people went out, then additional staff were required to support them in the community. At one location, a large noticeboard in the kitchen displayed pictures of staff members working that day, so people could easily see who would be supporting them on a particular day. One staff member said, "We have enough staff working here. Staff turnover here is low and if shifts need covering then staff can pick up extra, or the manager will cover the shift. There is never a problem, even if shifts need covering at short notice, then they are. We don't need to use agency".

Systems were in place to ensure staff were recruited safely, with appropriate checks made as to their

suitability to work in a care setting. Records confirmed this.

Medicines were managed safely. Guidelines were in place to ensure medicines that were given on an 'as required' (PRN) basis were managed appropriately. At one location, laxatives were administered covertly to one person; covert medicines are given without the person's knowledge. This medicine was needed to manage the person's particular health condition. The best interest's decision in relation to this had been taken appropriately and was documented, with input from healthcare professionals and staff. Medication administration records (MAR) had been completed by staff to show that people received their prescribed medicines as needed. Staff had been trained in the safe administration of medicines which was refreshed every two years and systems were in place to ensure staff competency to administer medicines was checked regularly.

People were encouraged to keep their rooms clean and to engage with housekeeping duties at each location. At one location, we observed people were supervised by staff when sorting out their laundry, since they had access to chemicals in the laundry room. When the laundry room was not in use, it was locked. Staff were trained in food hygiene and we saw kitchen areas were clean. We observed a member of staff encouraging and supporting one person to wash their hands thoroughly after making a meal.

Good

Is the service effective?

Our findings

People's needs, including their social needs, were holistically assessed. Technology was used to aid people's communication, such as laptops or tablet devices. For example, picture 'widgets' were used to support one person to communicate their choices and preferences. Pictures in books, magazines or on the internet assisted people in choosing what meal they would like to have as their menu choice for the week. A staff member told us, "People tell us the support they need. The shift leader will delegate who is supporting people and make sure everyone gets out to their activity, no-one is sitting around the house".

Staff had the skills, knowledge and experience required to deliver effective care and support. A range of training was available to staff, electronically or delivered face to face. New staff studied for the Care Certificate, a universally recognised, vocational, work-based qualification. The nominated individual of the provider said, "We do a bit of e-learning and refreshers are on-line, for example, in health and safety, food hygiene and infection control. We deliver minimal training to staff in moving and handling as our clients don't tend to need assistance in this area". Staff also completed training in the use of restraint and positive interventions. Some staff at one location needed to update this training which had expired in the first half of 2017. However, the team leader at this location told us that training had already been booked on this topic for later in June. Staff explained how they encouraged positive behaviour with people and in the use of methods such as calming or distracting people, to avoid the use of restraint. Staff demonstrated their understanding of cues and triggers, what worked for each person when they became distressed and how to keep them safe.

Staff received regular supervision meetings and their work performance was reviewed. Records showed that items discussed included actions from the last supervision, people and staff, training, safeguarding, development and any personal issues or concerns.

People were supported to eat and drink enough to maintain a balanced diet. Weekly menus were organised at each location and people were asked what they would like to eat, so their choices could be included. Records were kept of what people had eaten and of meals that proved popular. Where people had special dietary needs or for their food to be prepared in a particular way, care plans provided information about this for staff. Advice from specialists, such as dieticians and speech and language therapists, was sought and acted upon when needed. People's likes and dislikes were recorded and any cultural needs were catered for. For example, one person who was Muslim was provided with Halal meat and food was prepared in line with their religious beliefs. People were encouraged to help in the preparation of meals and to help themselves to drinks in the kitchen. One person said, "I have help with the oven" and was supported by staff with cooking. People helped with food shopping which encouraged their understanding of budgeting and healthy food choices.

Communication between staff at each location and across the organisation overall was effective. Daily handover meetings took place at which staff could discuss people's care and support needs and any information about people that staff needed to know to provide effective care. Staff could text or message each other and a communication book included information that needed to be shared amongst staff. Team

leaders and managers met monthly to share information across the different locations.

People had access to a range of healthcare professionals and services and records showed when health appointments took place. Where advice was provided from healthcare professionals, documents showed how staff followed this advice when supporting people. Health assessments recorded information about people's health and medical needs in a person-centred way. People had 'My Care Passports' which were used to share information with professionals in an accessible format. One person spent a lot of time in bed due to their mental health condition. Advice had been sought to ensure they did not develop pressure areas and a pressure relieving mattress had been bought. One person said, "I have a health check each month with my keyworker and staff make doctor's appointments for me, like for today, I have something that needs checking out". Where they were able, people were encouraged to be independent with travelling and attending their healthcare appointments, if they felt comfortable and were safe to do so.

People had their own rooms at each location and access to communal areas, including outdoor spaces.

People's capacity had been assessed and the appropriate paperwork was in place. Where people were deemed to lack mental capacity, best interests decisions were taken as needed. Some people required constant staff supervision and were not free to leave the location where they lived. For some people, decisions in relation to their care and welfare, property and affairs, were made by the Court of Protection and in line with the Mental Capacity Act 2005 requirements.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Staff used a consistent language and approach with people and we observed staff were encouraging, supportive and friendly with people. People were comfortable and happy in the presence of staff. Although able to understand and answer our questions, one person sought regular reassurance from the team leader in our conversation. The team leader encouraged the person to talk with us directly in a kindly, supportive manner. We asked the person whether they liked living at the location and about their relationships with staff. They said, "Staff are nice. I like living here, hanging out with the staff".

We observed staff supporting another person to get ready to go out and do their weekly shopping. The person engaged well with staff, who gave them verbal prompts about collecting bags and lists in a calm, encouraging manner. Staff advised the person that they might be hot later wearing their hoodie, but respected the person's decision to keep this on. The person was enthusiastic about the trip and asked lots of questions about where they were going and why. Staff were patient in their response to the person and helped them to understand what was happening. A staff member said, "We encourage people to be as independent as possible. [Named person] has it in his plan that we will link arms with him for reassurance in crowded places or when it is dark. I am there to support the person, not the other way around. With cooking I will cut things up as there is a risk if people use the sharp knives, but otherwise they do the rest". Another staff member said, "People can be challenging, but also very kind" and went on to describe people's various attributes.

Staff supported people to express their views and to be actively involved in decisions relating to their care and support. One staff member explained, "We know people well. The plans are person-centred and are detailed. We know and get on well with the parents and share information about people if they agree to it. We talk with people about their support and help to explain things to them. Everyone except [named person] can read, so we help him by giving him books which contain symbols so he can understand it better. We look at activities people want to do every day. We have monthly meetings with people and complete a monthly report about how everything is going. If people want, we will make changes, like arrange different courses at college when they want to switch. Everything we do is about the lads, what they want, their lives. They have dreams. Two people want to go on X Factor so we help them to practice their singing every night". They added, "People have support to stay in touch with their parents. People use Skype so they can talk to them face to face if they don't visit them that often".

People were treated with dignity and respect. Staff were observed to support people's privacy by knocking on their bedroom doors before entering and encouraging one person to close the door when they used the bathroom.

People were encouraged to be as independent as possible and to express their personalities in the choices they made, for example, with their bedrooms. Rooms we were invited to look at were personalised. For example, one person liked teddy bears so their bed was covered with bears. Another person loved the colour pink, so their bedroom was decorated in this colour. A third person showed us their room and had

helped to write guidelines which were displayed on their bedroom wall. These guidelines helped them to remember what had been agreed in relation to cleaning their room and tidying up cups and plates. Their drawers and wardrobe were labelled with written descriptions of clothes which served as prompts to help them put their own clean laundry away. People had the choice of whether they wanted to be with people or have privacy and space in their own room. Some locations had areas which staff could direct people to if they became upset or needed space. Wet rooms at some locations enabled people to be more independent, to wash themselves, which promoted their privacy and dignity. One person had the use of a shower chair which helped mitigate the risk if they should have a seizure and fall whilst taking a shower. This meant that because this person's risk had been appropriately assessed, they did not need staff to physically assist or watch them whilst they were in the shower.

Good

Is the service responsive?

Our findings

People received care and support that was responsive and personalised to their needs. Care plans contained detailed information about people, their needs, likes, dislikes and preferences and care plans were linked to risk assessments so staff knew how to support people. For example, care plans showed what assistance, if any, people required and how staff should communicate with people in relation to each part of their care plan. Objects of reference were used for one person because of their dual sensory impairment. A spoon placed in the person's hand indicated it was a mealtime, a flannel for a bath or wash, a mug meant a hot drink and a plastic beaker a cold drink. In this way, this person could understand what staff were trying to communicate. Some people used Makaton symbols as a way of communicating and staff were trained to use Makaton. People were involved in reviewing their care plans with their keyworkers, who co-ordinated all aspects of their care. Meetings took place each month and records showed what was discussed at each meeting, how people felt, any changes to be made in their care and actions arising. Where possible, people had signed their care plans to confirm their understanding and agreement.

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so they can communicate effectively. Care plans were written in an accessible format. The nominated individual of the provider said, "Because of software available, we can produce information to meet people's individual needs. Social stories can be written and we can use comic strip sequences too. Things can be tweaked to meet people's needs". Apps on smart-phones were also used to good effect in communicating with people.

Where people displayed behaviour of a challenging nature, staff used positive behaviour support to good effect and were pro-active in managing people's anxiety and distressed states. Behaviour support plans provided information to staff on the setting of events leading to challenging behaviour and prevention strategies to be employed. These plans provided exceptionally detailed information so staff could provide the right support to meet people's behaviours.

People's diverse needs were addressed and catered for. For example, one person had been a member of a particular religious sect and staff were aware of how to support them. Another person was transgender and was supported by staff to attend a support group for Lesbian, Gay, Bi-sexual and Transgender (LGBT) people.

We asked people how they spent time at home and out in the community. One person said, "Staff help me decide what goes on the planner. I can tell staff what I want to do. I like to go out to the pub and to see shows. Last night I went to see the Ladyboys of Bangkok which was great". They added, "I see my family every weekend and staff help me to go and see them. Staff know my routine. I like to watch telly and spend time in my room. It can get a bit much with the others sometimes. I do my own thing quite a lot". The nominated individual of the provider said, "Everyone has their own activity plan. Some people like routine and structure and some plan each week". People were involved in a wide range of activities, for example, some went to college, were involved in voluntary work or went to day centres. People were encouraged to

go out into the community and one staff member said, "[Named person] loves going out for tea, banger racing and walks. He goes to the cinema and enjoys house shopping". This person also enjoyed music therapy, art therapy and aromatherapy. Another person, who required a high level of support from staff in the community, was limited in what they could do in the way of activities. We explored this further with a member of the senior management team and they told us this was being actively pursued, but there had been problems with funding from the person's local authority and in ensuring their cultural needs were met appropriately when out in the community.

Complaints policies were written in a way that people could understand according to their different needs. Complaints policies were changed for each location so that people had photos of the building they lived in and photos of their support staff and the management team. The team leader at each location was the first point of contact for any complaints, but people could also approach members of the management team if they wished. We were told that informal complaints were dealt with promptly and formal complaints were dealt with within five days. No formal complaints had been received recently.

Good

Is the service well-led?

Our findings

There was a registered manager in post. 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. The nominated individual of the provider told us that in practice the responsibility for managing each location lay with a team of managers and the day-to-day operation was the responsibility of team leaders at each location. The nominated individual said there were no plans to grow the service, even though frequent referrals came through for placements from different authorities. They explained that support was provided to a maximum of four people at any one location and that this worked well. Finding suitable properties to cater for people's needs could be difficult, as well as recruiting the right staff, and providing personalised care for people took priority. One team leader explained, "The whole ethos is person-centred, to do what is best for people. The approach the organisation encourages and promotes is positive behaviour support. How we support each person. There's no culture of blame".

Staff felt supported by their line managers and by the organisation as a whole. One staff member told us they could discuss anything with their line manager who they described as, "very supportive". They told us that senior managers were very open and honest and, "always happy to sit and chat about anything". Various members of the management team regularly visited each location and team leaders told us there was always someone available at the end of a phone too. A team leader said, "This is the best company I've worked for. The approachability of Head Office and all the managers who know all the service users and have a good understanding of people's needs". Another team leader told us, "I have assistance from my senior managers. The organisation is very open and inclusive and communicates well. They are open about incidents and will share information. There was an incident where staff went to court in another service and we were encouraged to discuss this with our teams. It is really good to be open. I try to be consistent with my staff and there is the 'on-call' so there is always someone to talk to".

Staff were clear about their roles and responsibilities and worked collaboratively in their teams. At one location we visited, the team leader worked shifts alongside staff for four shifts each week, so they had a good oversight of the culture amongst the staff team. At another location, a staff member said, "The manager [team leader] is great. I wouldn't work for anyone else. She is easy to approach if we have any concerns and will sort out the problem. Rotas are fair and she is flexible with shift arrangements if I have something on. The service vision is all about people. We have monthly staff meetings and are involved in developing the service. If we make suggestions then things will change, like with the 'widget' board for rotas and activities. We changed the folder with the widgets in it and the board as it wasn't very accessible for staff or people and it is easier to access now". A staff survey was sent out in 2017 with 54 responses. Staff were asked how they felt about their employment with the organisation and of their roles in supporting people. Results were positive.

People and their relatives were asked for their feedback about the service and surveys for people were presented in an accessible format. People were asked for their comments about the food, whether they felt

safe, their room, visitors to the home and whether they were involved in planning their care. All comments were favourable. Where people had made suggestions about changes they would like to happen where they lived, these were recorded and acted upon. For example, people at one location decided they did not like nuts, so were offered fresh fruit as an alternative. Seventeen relatives had also responded to surveys and results were satisfactory.

Reviews were undertaken at each location on a regular basis, usually monthly, by a member of the senior management team. These reviews covered areas such as staffing, staff meetings, training, support plans, activities, medicines, fire safety, general maintenance and cleanliness. Where actions were identified, these were recorded and addressed within stated timescales. Accidents and incidents for each location were analysed for any patterns or trends, so changes could be made if needed. Notifications that the provider was required to send to us by law had been completed appropriately. Ratings awarded from the last inspection were on display at locations and on the provider's website.

The nominated individual of the provider attended a range of events to network with others, updated their knowledge and skills and shared information as needed. For example, they attended Skills for Care events, the West Sussex Learning Disability Provider Forum and a network for Positive Behaviour Support. This meant that the provider and senior management team were kept abreast of the latest information in relation to people who received support and to drive continuous improvement.