United Response

United Response - Bristol DCA

Inspection report

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Date of inspection visit:
05 April 2017
06 April 2017

Date of publication:
30 May 2017

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

Bristol DCA United Response is a domiciliary care service providing care and support to people in their own homes. At the time of our inspection 13 people with learning disabilities were using the service at five separate addresses.

The service people received was called 'supported living'. This meant people received personal care from the provider in their own homes for which they had a separate tenancy agreement with a housing provider.

The inspection was announced. The provider was given 48 hours' notice because we wanted to make sure the registered manager and staff would be available to speak with us. The inspection was carried out by one adult social care inspector.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. 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.

At our last inspection in November 2015 we found, a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. This was because the registered manager and provider had not always submitted notifications of incidents to CQC as required by law. At this inspection we saw the provider had taken the action they had identified in their action plan. As a result improvements had been made and the service was no longer in breach of this regulation.

During this inspection we did not find any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or the Health and Social Care Act 2008 (Registration) Regulations 2009

At the last inspection, the service was rated Good overall.

At this inspection we found the service remained Good.

Why the service is rated good:

People received a service that was safe. The registered manager and staff understood their role and responsibilities to keep people safe from harm. People were supported to take risks, promote their independence and follow their interests. Risks were assessed and plans put in place to keep people safe. There was enough staff to safely provide care and support people. Checks were carried out on staff before they started work to assess their suitability to support vulnerable people. Medicines were well managed and people received their medicines as prescribed.

The service was effective in meeting people's needs. Staff received regular supervision and the training needed to meet people's needs. Arrangements were made for people to see a GP and other healthcare professionals when they needed to do so. The registered manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and, worked to ensure people's rights were respected.

People received a service that was appropriately caring and maintained a clear focus on promoting independence. They were cared for and supported by staff who knew them well. Staff treated people with dignity and respect. People's views were actively sought and they were involved in making decisions about their care and support. People were supported to maintain relationships with family and friends.

The service was responsive to people's needs. People received person centred care and support. They were offered a range of activities both at the service and in the local community. People were encouraged to make their views known and the service responded by making changes.

People benefitted from a service that was well led. The vision, values and culture of the service were clearly communicated to and understood by staff. A comprehensive quality assurance system was in place. This system was based upon regular, scheduled audits which identified any action required to make improvements. This meant the quality of service people received was monitored on a regular basis and where shortfalls were identified they were acted upon.

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 has improved to Good. The registered managers and service managers were well respected and provided good leadership and management. The vision, values and culture of the service were clearly communicated to and understood by staff. Comprehensive quality assurance system were in place.	Good

United Response - Bristol DCA

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 5 and 6 April 2017. The inspection was carried out by one adult social care inspector and was announced.

The last full inspection of the service was in September 2015. At that time we rated the service overall as 'Good'. However, we rated the service as 'Requires Improvement' under our key question heading of; Is the service well-led? We also identified a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. Following our inspection the provider sent us an action plan detailing the action they would take to ensure the required improvements were made.

Prior to this inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

We contacted 11 health and social care professionals involved with the service and asked them for some feedback. Their comments have been incorporated into this report.

We spent time at the provider's offices and were invited to visit people at their homes. We spoke with a total of five people at three separate addresses. We spoke with eight staff, including the registered manager, three service managers and four support workers. We were also able to gain the views of relatives of three people through email correspondence.

We looked at the care records of seven people using the service, two staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Good

Is the service safe?

Our findings

People we were able to talk with told us they felt safe. Comments included; "Yes, I'm safe in my home" and, "The staff help to keep me safe". We observed people receiving support and saw they reacted positively to staff and seemed relaxed and contented with them. Relatives said they felt people were safe. Health and social care professionals also told us they felt people were kept safe. One professional commented, "The service provided seems safe".

Staff knew about the different types of abuse and what action to take when abuse was suspected. Staff described the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to concerns of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Easy read information was on available and on display, this provided people with a clear explanation of what to do if they felt they had been subjected to any abuse. The provider had appropriately raised safeguarding alerts in the 12 months before our inspection. On each of these occasions the provider had taken the appropriate action. This included sharing information with the local authority and the Care Quality Commission (CQC).

The service also had a whistle blowing policy and procedure. This policy protected employees against detrimental treatment as a result of reporting bad practice. Staff we spoke with were able to describe 'whistle blowing' and knew how to alert senior management about poor practice.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. These covered areas of daily living and activities the person took part in, encouraging them to be as independent as possible. People using the service had very different needs. For example, one person went out independently and another required three staff to support them when going out. The individual risks people faced and how they were to be minimised had been carefully assessed and planned for. Staff told us they had access to risk assessments in people's care records and ensured they used them. Talking with staff it was clear they had a good knowledge and understanding of people's risk assessments and the measures required to keep them safe. Risk assessments and management plans were regularly reviewed by senior staff, with the involvement of other professionals where required.

The service had emergency plans in place to ensure people were kept safe. These plans included information on finding alternative accommodation for people if they needed to evacuate their home. They also included individual emergency plans to keep people safe. For instance, to meet people's medical needs and to assist them to evacuate in the event of a fire. Staff had a good understanding of these plans.

The provider investigated accidents and incidents. This included looking at why the incident had occurred and identifying any action that could be taken to keep people safe. For example people's risk assessments and support plans had been reviewed following accidents and incidents.

People were supported by sufficient numbers of staff who had the appropriate skills, experience and

knowledge to meet their needs. People confirmed there were enough staff. Care records detailed when they needed care and support. This had been agreed with people, their families and other health and social care professionals. We looked at staff rotas for each address and saw staffing was arranged in accordance with people's assessed needs as detailed in their care plans. Each address had a dedicated team of staff who knew people well. Service manager's monitored the hours people received and we saw people were provided with the staff time identified in their care plans.

People were protected from the recruitment of unsuitable staff. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. References were obtained from previous employers.

There were clear policies and procedures for the safe handling and administration of medicines. Staff administering medicines had been trained to do so. In addition to this training all staff who gave medicines to people had their competency assessed annually by their manager. Some people required assistance to take prescribed medicines. Where this was the case the support the person required was clearly documented in their care plan, with medication administration records maintained and completed. Each person had individual guidelines in place headed, 'How I like to take my medicines'. This showed people's individual preferences were taken into account. One person administered their own medicine for diabetes. An individual risk assessment and plan to keep the person safe had been completed. Guidelines were in place that outlined the role and responsibility of staff in this process. Where people were prescribed medicines 'as required' to help with certain health conditions, clear guidance was in place for staff to follow. Medication administration records demonstrated people's medicines were being managed safely. Where staff administered medicines to people they had signed to record they had been given.

The provider had an infection prevention and control policy in place. Staff told us they had access to the equipment they needed to prevent and control infection. They said this included protective gloves and aprons. A designated staff member at each address had responsibility for infection prevention and control at each of the addresses where a service was provided. Staff had received training in infection control.

Good

Is the service effective?

Our findings

People received an effective service that met their individual needs.

People we were able to talk with said their needs were met. When spending time with people we saw staff met people's needs effectively. This included identifying when people required personal care or support and were not able to ask, as well as interacting with people and engaging them in activities. Relatives said people's needs were met.

People's care records documented how people's needs were met. Some people using the service had complex needs and required individual care and support to meet their communication and health needs. Some people also needed care and support to help them when experiencing anxiety and distress. Individual plans were in place for these areas and specialist input from other professionals had been obtained. People's care records contained information on hospital appointments and communication with healthcare professionals.

We viewed the training records for staff which confirmed staff received training on a range of subjects. Staff received training in core areas such as keeping people safe from harm and first aid, with some staff receiving training in specialist areas such as caring for people with diabetes, epilepsy awareness, working with people with autism and positive behavioural support. Staff said they had received the training required to carry out their roles effectively.

Newly appointed staff completed their induction training. An induction checklist monitored staff had completed the necessary training to care for people safely. The induction training programme was in line with the new Care Certificate that was introduced for all care providers on 1st April 2015.

Formal and 'on the job' supervision of staff was being used to improve performance. Formal supervisions are one to one meetings a staff member has with their supervisor. 'On the job' supervision is when a staff member's supervisor joins them when they are providing care to assess how effective they are. We saw service managers made good use of these observations during formal supervisions. Staff told us they felt they benefitted from informal role modelling and coaching from service managers and, from their formal supervision sessions.

Annual appraisals were carried out with staff. Staff said these were useful. We saw that these had been carried out thoroughly and included feedback to staff on their performance, details of any additional support the staff member required and a review of the individual's career goals and training and development needs.

We carried out checks to identify if the provider was complying with the requirements of the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so 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.

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA). The registered manager, service manager and support staff had a good understanding of the MCA. Staff understood their responsibilities with respect to people's choices. Staff were clear when people had the mental capacity to make their own decisions, and respected those decisions.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Where people had been assessed as not having the capacity to make a specific decision, a process of 'best interests' decision making had been followed. This was clearly documented and we saw it sought to determine the decision the person would make themselves if they were able to. For example, a thorough process for deciding on the appropriateness of spending a large sum of money had recently been undertaken with one person who was unable to make the decision themselves. This had resulted in a comprehensive record of decision making over purchasing a large individual chair and battery packs for their wheelchair.

The provider had ensured people had individual tenancy agreements in place. Some people's tenancy agreement for their home had not been signed. The registered manager explained this was because they had been assessed as lacking the capacity to make decisions regarding this. They had a plan in place to ensure these would be signed by an appropriate signatory. This showed the provider took their role seriously in protecting and promoting people's rights in this area of their lives and, ensuring they were protected by housing legislation.

Some people's needs meant they required continuous supervision to keep them safe and did not have the freedom to leave their home on their own. The provider had identified this amounted to a deprivation of their liberty.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people are living in their own homes any application for authorisation must be submitted to the Court of Protection. The provider had submitted applications to the correct body and were complying with the requirements of authorisations received.

Staff supported people to plan their own menus, shop for food and participate in the preparation of meals. Where people needed assistance with eating and drinking this was documented in people's care records. Aids and adaptations to help had been provided and we saw that one person had received support to hold their spoon and toothbrush themselves. People's food and fluid intake was monitored to ensure they ate and drank sufficiently.

People's changing needs were monitored and their health needs responded to promptly. Care staff had identified when people were unwell and contacted people's GP's and other health and social care professionals when required. As a result people had received assistance from a wide range of professionals including; occupational therapists, speech and language therapists, physiotherapists, community nurses, social workers and behavioural support specialists. We saw support plans had been put in place as a result of this and were implemented by staff. Health and social care professionals commented positively regarding staff support to people. They said, "I believe that staff work hard in very difficult circumstances to meet (Service User's name) needs" and, "The staff are regularly in touch for advice and follow it when given".

Good

Is the service caring?

Our findings

People we were able to talk with told us they felt staff were caring. Comments included; "The staff are good to me, they're kind" and, "I like all the staff, they're good". Relatives also said staff were caring.

The service was based upon the principles of 'active support'. This is a way of providing assistance to people which focusses on making sure they are engaged and participating in all areas of life. This approach requires staff to focus on supporting people to become involved in everything that is going on in their home, as well as providing meaningful activities based upon the things they are interested in. The main role of staff under this approach becomes one of 'supporting' people to do as much for themselves as possible. It is based upon research and best practice and can often be challenging for staff used to a more traditional 'caring' role.

We found staff understood the active support model and were skilled at engaging with and involving people. They succeeded in this whilst also demonstrating a kind, caring and compassionate approach. They clearly knew the people they supported well and spoke to people in a calm and sensitive manner using appropriate body language and gestures. Service managers and staff spoke passionately about this approach and how it had helped people learn new skills and as a result gain in confidence.

People's care records included a communication plan which described how people's communication needs were met. We saw this included information on Makaton used by one person. Makaton is a language system that uses signs and symbols to help people with limited verbal communication. Staff were able to explain to us how people's communication needs were met.

Staff worked to ensure people were as involved in the planning of their care and support as possible. Where required and appropriate, family, friends or other representatives advocated on behalf of the person using the service and were involved in planning care and support arrangements. People received a service based upon their individual needs. People's needs were assessed in relation to what was important to the person and what was important for the person. This meant the service was planned and delivered taking into account what people needed and what they wanted.

The provider had a keyworker system in place. This involved an identified staff having key responsibility for ensuring a person's needs were met. Staff told us this system allowed them to get to know the person they were keyworker for well and ensure the needs of the person were met. Keyworkers met regularly with people and recorded their views. A care plan review involving the person and their family was carried out every three months. These reviews were based upon the views of people and family and staff close to them. They provided an update on how their needs had been met and identified new objectives for the person.

Staff recognised and promoted the involvement of family and friends. Some people told us about their family and friends and how they maintained contact with them. People's care records detailed how people were supported to do this. This included supporting people to visit family and maintaining regular contact.

Staff respected people's privacy and maintained their dignity. When visiting people staff introduced us and asked if people wanted to talk with us in private. Before entering people's rooms staff knocked on their doors and either waited to be invited in, or if they were unable to respond verbally, left an appropriate amount of time before entering.

The provider had an up to date policy on equality and diversity. Staff had received training on equality and diversity and understood the importance of identifying and meeting people's needs. The care planning system used included an assessment of people's needs regarding, culture, language, religion and sexual orientation. Talking with staff it was clear they understood the values of the service and, recognised the importance of ensuring equality and diversity and human rights were actively promoted.

Good

Is the service responsive?

Our findings

People received a service that was responsive to their individual needs.

Their care and support was planned and delivered using a range of person centred planning tools. Person centred planning tools are designed to encourage staff and other people involved in planning care and support to think in a way that places the person at the centre. We saw these included information on people's life histories, their likes and dislikes and detailed information on how they should be cared for and supported.

Care plans were held at the agency office with a copy available in people's homes. We viewed the care plans in people's homes we visited. We saw these were up to date and consistent with those held at the office. Staff said the care plans held in people's homes contained the information needed to provide care and support.

People were involved in a range of individual activities. Each person had a weekly plan of regular activities. Activities were based upon people's hobbies and interests and their likes and dislikes. People chose additional activities from looking at photographs of actual activities. This was done at weekends and activities were planned based upon these choices. Staff worked flexibly to support these activities. They told us people were able to engage in individual activities on both and planned and spontaneous basis because of the way staffing was allocated to support this. People received support to go on short breaks and holidays. They told us they enjoyed these holidays. Some people using the service had their own vehicles. Others were supported to make use of public transport and taxis. We were told that when staffing to support activities was planned, the need for staff to be able to drive was taken into account. People, relatives and staff all said there were enough activities. On the days of our inspection people were supported on a range of individual activities. These included; visiting the zoo, a trip to the coast and voluntary work at a farm.

People spoke enthusiastically about the activities they were involved with. One person told us how they had been supported to set up a community allotment project. This had involved applying for and securing a site with the council, developing a fundraising strategy and presenting the idea to senior managers in United Response. People had now cleared the site and begun planting on a large scale. They were clearly proud of their achievements. The service manager said, "(Service User's name) presented the idea to the area and divisional management team. We have supported people to raise funds and, link in with local community groups, with the aim of making the allotment a space for community use, as well as an activity for people".

When people engaged in new activities, staff completed a learning log. This learning log recorded whether the person had enjoyed the activity and what had gone well and not so well. This allowed staff to learn more about activities people enjoyed and adapt the activity and support provided to suit the person's preferences. We saw this system had resulted in staff making changes to activities. For example, altering the times people participated in an activity to avoid crowds.

A number of people using the service had complex health needs. These included diabetes, epilepsy and the

need for intensive behavioural support. Health and social care professionals told us staff worked positively with them to ensure people's needs were met and, any changes identified and responded to.

People had moved to one supported living service from residential care within the last 12 months. They required staff to support them to manage their behaviours. The staff team supporting people had been very large and this had resulted in manager's having some concerns about the consistency of their support. As a result, they had identified smaller teams of staff to support specific people. This had resulted in a decrease of incidents. Staff told us people had benefitted greatly from this move. They said; "They now receive a more individualised service in their own home", "People are far more independent now" and, "We don't get anywhere near as many incidents now". Positive behavioural support plans had been developed and were being implemented. These were built around the individual's needs and aimed to ensure people were given the support they required. These plans were regularly reviewed with the involvement of relevant professionals.

Some people required support to manage their epilepsy and diabetes. Staff kept clear records of their health conditions and passed any information of concern to relevant professionals. Records were kept of communication with health professionals and, people's support plans were updated when required. Staff had recently identified one person was falling more frequently. Referrals had been made to a number of professionals to try to determine the cause. In the meantime, staff had been made aware of the additional risks this posed to the person and how these were to be minimised.

Staff supporting one person living on their own had advocated strongly for them at a time of crisis. This had involved discussions with a number of agencies to ensure their needs were met. This had been a difficult process and the person had been kept safe as a result of the tenacity of staff. The service manager explained they were working closely with the person, their family, housing provider and others.

People said they felt able to raise any concerns they had with staff and these were listened to. Relatives also said they could raise any concerns and felt confident these would be addressed. There had not been any complaints regarding the service in the 12 months leading up to our inspection. The registered manager explained the process used if complaints were received. They said they welcomed complaints and, any received were investigated within timescales set in the provider's policy, with the outcome reported to the complainant.

Good

Is the service well-led?

Our findings

People received a service that was well-led.

They were supported in a person centred manner and encouraged to be as independent as possible. Throughout our inspection we found the registered manager and service managers demonstrated a commitment to providing effective leadership and management. They were keen to ensure a high quality service was provided, care staff were well supported and managed and, the service promoted in the best possible light.

The management structure was clear and effective. The registered manager delegated the day-to-day operation of the supported living services to the three service managers, who managed the support staff at those addresses. The registered manager told us that although they felt the service was managed well, they had looked into ways of further developing this. As a result they had recently introduced new roles of 'practice leads'. They explained they wanted these posts to provide further career development for support staff and strengthen the leadership and management. This showed the provider and registered managers were looking into ways of further improving the service provided.

People told us they liked the registered manager and service managers and were able to talk to them when they wanted. Staff spoke positively about the management and felt the service was well led. They said, "We get really good support from (Service Manager's name) and can get hold of (Registered Manager's name) whenever we need to", "As staff we are very well supported" and, "Managers have a clear focus on providing person centred care and that's kept at the centre of what we do". Relatives also spoke positively about the leadership and management of the service. Health and social care professionals also commented positively on the management of the service. They said, "I have found the manager of (Supported Living address) to be very willing to communicate with me about any concerns I have about the service they provide" and, "The communication with manager's and staff is very good".

Staff said they were able to contact a manager when needed. The registered manager told us the service operated a 24 hour on call service, for staff to contact a senior person for advice, guidance or support.

Regular staff meetings were held. The staff teams based at each address met to keep them up to date with changes and developments. We looked at the minutes of previous meetings and saw a range of areas were discussed. These included; individual care and support arrangements, activities and staff related issues. Staff told us they found these meetings helpful. Records of these meetings included action points which were monitored by the registered manager to ensure they were completed.

Systems were in place to check on the standards within the service. The provider sent annual satisfaction surveys to people using the service and their family and friends for them to comment on the service. The results of the most recent surveys were positive. These included weekly, monthly and quarterly schedules of quality audits for each address. Service managers completed audits on supported living services they were not responsible for directly managing, these were overseen by the registered manager. The registered

manager ensured identified actions were completed. An annual quality assurance review was carried out by the provider. This drew upon the findings of quarterly audits and satisfaction surveys received. External audits had been completed by local authorities responsible for funding people using the service. The outcome of these had been positive. One stated; 'What I saw was of a good/very good quality and I was particularly impressed by the person centred and innovative approach to care and support provision'.

Accidents, incidents, complaints and safeguarding alerts were appropriately reported by the service. The manager investigated accidents, incidents and complaints. This meant the service was able to learn from such events. The registered manager had a good understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and ensured they kept up to date with best practice and service developments.

Health and safety management was seen as a priority by managers. Action had been taken to minimise identified health and safety risks for people using the service, staff and others. For example, environmental risk assessments had been completed for each address and a lone working risk assessment had been completed to cover staff working alone at the provider's office.

The policies and procedures we looked at were comprehensive and referenced regulatory requirements. Staff we spoke to knew how to access these policies and procedures. This meant clear advice and guidance was available to staff.

The registered manager knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriate notifications from the service during the 12 months before this inspection.

Copies of the most recent report from CQC was on display at provider's office and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily assess the most current assessments of the provider's performance.

At the end of our inspection feedback was given to the registered manager and the three service managers. They listened to our feedback and were clearly committed to providing a high quality service valued by people and families. They spoke with us about their future plans for the growth and development and, improvement of the service provided to people.