Affinity Trust

Affinity Trust - Domiciliary Care Agency West Kent

Inspection report

Suite 2 & 3 Henwood Pavilion
Henwood
Ashford
Kent
TN24 8DH

Tel: 01233665324
Website: www.affinitytrust.org

Date of inspection visit:
18 July 2016
19 July 2016
20 July 2016

Date of publication:
08 September 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 18, 19 and 20 July 2016, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. At the previous inspection on 15 July 2014 no breaches were found.

Affinity Trust – Domiciliary Care Agency West Kent provides care and support to adults in their own homes. The service is provided to people who have a learning disability, some of whom live on their own and some share with other people using the service. At the time of this inspection there were 27 people receiving support with their personal care. The service provided one to one support hours to people, most people were supported 24 hours a day although during this time may share staff for a period of time with another person living in the same house, such as in the evening or at night. The service is delivered across Kent.

The service is run by a registered manager, who was registered in October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives were involved in the initial assessment and the planning of their support. Support plans contained details of people's wishes and preferences, but the level of detail was not always consistent. People's independence was encouraged wherever possible, but this was not always supported by the support plan. Risks associated with people's support had been identified and clear guidance was in place to keep people safe.

People had their needs met by sufficient numbers of staff. People received a service from a small team of staff, who were recruited specifically to match the people they supported. New staff underwent an induction programme, which included relevant training courses and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role, which was refreshed regularly to ensure staffs knowledge remained up to date. Some staff had gained qualifications in health and social care.

People were supported to maintain good health and attend appointments and check-ups. People's medicines were handled safely.

People's consent was gained for the support they received and they were supported to make their own their own decisions where possible, sometimes using pictures, photographs or objects of reference. Most people had an appointee to manage their finances. One person had Lasting Power of Attorney arrangements in place. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people

who know the person well and other professionals, where relevant. The registered manager understood this process.

People and relatives felt staff were kind and caring. People were relaxed in staffs company and staff listened and acted on what they said. People were treated with dignity and respect. Staff were kind and caring in their approach and knew people and their support needs.

People and relatives felt people were safe using the service. The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People had opportunities to provide feedback about the service provided. Any negative feedback was used to drive improvements to the service. Audits and systems were in place to ensure the service ran effectively and people received a quality service.

The provider had a mission statement and staff followed this through into their practice.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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.

People received their medicines when they should and safely.

Risks associated with people's care had been identified and guidance was in place to keep people safe.

People's needs were met by sufficient numbers of staff and these were kept under review.

Is the service effective?

Good

The service was effective.

People's support was delivered by regular staff, who were familiar with people's preferred routines.

People received support from trained and supported staff. Staff encouraged people to make their own decisions and choices.

People were supported to maintain good health. Staff worked with health care professionals, such as occupational therapists

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff adopted a kind and caring approach.

Staff supported people to develop their independence where possible.

Staff listened acted on what people told them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support plans reflected their wishes and preferences, although were not always consistent in the level of detail.

Support plans did not always support developing people's independence.

People and relatives had opportunities to provide feedback about the service they received.

People were not socially isolated and were supported in a variety of activities and to access the community.

Is the service well-led?

Good

The service was well-led.

Communication within the service was good and staff worked as a team to ensure people received a quality service.

There were audits and systems in place to monitor the quality of care people received.

There was an open and positive culture within the service, which was focussed on people. Staff were aware of the provider's mission statement and this was followed through into their practice.

Affinity Trust - Domiciliary Care Agency West Kent

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 18, 19 and 20 July 2016 and was announced with 48 hours' notice. The inspection carried out by one inspector.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information, such as the previous inspection report, we held about the service, we looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included four people's care plans and risk assessments, three staff recruitment files, staff training, rotas, medicine and quality assurance records and surveys results.

We visited four people who were using the service in their own homes and spoke with and/or made observations of their interactions with staff. We spoke with three relatives, the registered manager (operations manager), a second operations manager, the divisional director, the administrator and four members of staff.

We also used the feedback from the provider's most recent (May 2016) quality assurance surveys where surveys were returned from people who use the service, relatives and professionals.

Following the inspection we received feedback from a social care professional who had had contact with the service.

Good

Is the service safe?

Our findings

One person was able to tell us they felt safe when staff were in their home and when they provided support. Relatives agreed that people were safe using the service.

This person and relatives felt people received their medicines when they should and staff handled them safely. At the time of the inspection no one was able to manage their medicines themselves and all administration was undertaken by staff.

There was a clear medicines management policy in place. Staff had received training in medicine administration and they told us they had their knowledge and competency checked with observations of their practice. Medicine Administration Records (MAR) charts showed people received their medicines when they should.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage pain, there was clear individual guidance for staff on the circumstances in which these medicines were to be used safely and when they should seek professional advice on their continued use, to help ensure people received these medicines consistently and safely.

Risks associated with people's health and welfare had been assessed and procedures were in place to keep people safe. For example, health concerns, epilepsy, medicine management, personal care, accessing the community, decision making and communication and choking. Where people had behaviours that challenged, guidance was in place to help staff manage these safely and positive behaviour support plans were in place showing possible triggers, early warning signs and positive strategies to enable early interventions.

Accidents and incidents involving people were recorded. Senior staff and management reviewed each accident and incident report, to ensure that appropriate action had been taken following any accident or incident, to reduce the risk of further occurrences. Reports were then sent to the health and safety department who monitored for patterns and trends.

One person told they would speak to their service manager if they were unhappy. During the visits to people own homes the atmosphere was happy and relaxed. Staff were patient and people were able to make their needs known, either verbally or by using expressions and behaviours or Makaton (the use of signs and symbols to support speech). Staff had received training in safeguarding adults; they knew the procedures in place to report any suspicions or allegations. There was a clear safeguarding policy in place. The registered manager was familiar with the process to follow if any abuse was suspected in the service; and knew the local authority's safeguarding protocols and how to contact the local authority's safeguarding team. Following learning from an incident new sealed money packs had been introduced where staff were responsible for handling people's monies for added protection.

People were protected by recruitment procedures. We looked at three recruitment files of staff that had

been recently recruited. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People had their needs met by sufficient numbers of staff. Staffing levels were provided in line with the support hours contracted with the local authority. Most people were supported 24 hours a day although during this time may share staff for a period of time with another person living in the same house, such as in the evening or at night. In addition some people had two staff to support them in the community. Senior staff were responsible for covering the rotas taking into account people's support needs. The service had staff employed on permanent contracted hours and bank staff (staff that worked as and when required). Management kept staffing numbers under review. At the time of the inspection the registered manager told us there were 12.8 full time vacancies and the service was recruiting. Regular agency staff were used to cover vacancies and staff leave. There was an on-call system out of office hours covered by senior staff.

Good

Is the service effective?

Our findings

One person told us they were "Happy" and "Liked" the support they received. In a recent quality assurance survey undertaken by the provider people indicated that they were happy with the support they received. One person commented to what the service does well, 'mostly have the right staff'. Relatives were satisfied with the support their family members received.

One social care professional told us "The care and support plan is followed and staff ensure (person) received a good quality of life despite their health issues".

Care plans were put together using words, pictures and photographs and contained a communication profile. This detailed how a person communicated including a list of the ways they made their needs known. For example, if one person was thirsty they would sign (Makaton) for a drink or point to the fridge for milk. The profile had been put together with a speech and language therapist. The profile went onto say under their preferred method of communication 'I like people to look at me when they are talking to me, giving me strong eye contact. The person talking to me needs to talk slowly and plainly using facial expressions to underline the meaning of the conversation'. The profile contained photographs of some signs that were individual to the person. In addition to verbal communication, pictures and photographs staff also used objects of reference to aid people's communication.

One person and relatives told us people received their support from a team of regular staff. Each person's support plan contain information 'Matching Staff Chart' about what type of staff member they wanted to support them. This was then used to ensure the right member of staff was recruited to support a person or people sharing a home. Second interviews were also held in the person's home so observations of interactions could be gained to ensure they were suited. People were then supported by a small team of staff that usually worked mainly within a house or perhaps two houses to ensure people received good continuity.

People's consent was achieved by staff discussing and asking about the tasks they were about to undertake and some people's behaviour would let staff know if they did not consent. In a recent quality assurance survey people indicated that they were supported to make their own decisions. Support plans contained information about how to best facilitate people making their own choices and decisions where possible. Support plans demonstrated that people would be offered choices, such as what to wear, where to go and what to eat or drink.

Staff were trained in Mental Capacity Act (MCA) 2005. The registered manager told us most people had an appointee to manage their finances. One person had lasting Power of Attorney arrangements in place. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People's capacity had been assessed in relation to certain decisions and the decision making had included relatives and appropriate professionals.

Relatives told us they felt staff had the right skills, experience and training to meet people's needs. Staff understood their roles and responsibilities. Staff had completed an induction programme, which included reading, orientation, attending training courses and undertaking knowledge competency tests. In addition staff also undertook shadowing of experienced staff until it was felt they were competent to work alone. The induction was based on Skills for Care Care Certificate, which was introduced in April 2015. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Staff had a six month probation period to assess their skills and performance in the role.

The registered manager said staff received their initial training and then this was refreshed every one to three years depending on the subject. Training included health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff received some specialist training, such as Autism, epilepsy, person centred planning and support and communication, understanding learning disabilities and positive behaviour support.

Fifty one of the one hundred and thirty two staff had a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff told us they had one to one meetings with their manager where their learning and development was discussed. Records showed staff had received regular one to one meetings. Team meetings were held where staff discussed people's current needs, good practice guidance and policies and procedures. Staff said they felt well supported.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. People were supported to plan, shop and perhaps help cook their meals. Staff encouraged a healthy diet wherever possible and talked about one case where the success had led to a person being able to stop their medicine for managing their constipation. Support plans showed that some people had plate guards to aid their independence. Where there were risks relating to nutrition, measures were in place to reduce these risks. For example, foods were cut into small pieces when there was a risk of a person choking or staff would sit with the person to ensure they ate slowly. One person received a fortified diet to ensure they maintained a healthy weight.

People's health care needs were met. Records showed people were supported to attend appointments and check-ups with dentists, doctors, chiropodist and opticians. Appropriate referrals had been made to health professionals. For example, one person had recently been referred to the hospital diabetic service and occupational therapists had assessed for equipment, such as an adapted stool and shower chair. A relative told us that staff were quick to pick up on any small health issue and always made sure their family member saw the doctor.

Good

Is the service caring?

Our findings

One person told us staff were caring and listened to them and acted on what they said. In recent quality assurance surveys people indicated that they felt staff listened to them. One person commented, 'Staff are good to me'. Other comments included, 'I'm happy. I like (staff member) the best'. 'Staff do their upmost to support me'. Observations showed this included the use of good humour.

Recent survey comments from relatives included, 'My (family member) is very happy with his new life now. All staff are kind to him and make his life carefree'. 'Excellent service. The care team in particular put my (family member) first in all matters'. 'Dedicated carers, always put (family member's) interest first. Two staff long term has provided stability and continuity for years'. 'Staff are always helpful'. 'Good team who love and care for my (family member)'.

During the inspection staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily. Staff used different forms of communication to ensure people were able to make their needs known. For example, staff used pictures, photographs and objects of reference. Staff also used Makaton to communicate effectively with people. Staff involved people in our discussions about things they had done or enjoyed.

The service had received some compliments letters about the support provided. One relative had written 'To the amazing team at (specific service) with much appreciation for all you do'. Another relative had written 'We would like to express our thanks for all your help and hard work in helping (family member) make that transition. She made some very strong connections with her care team, made great progress over her time with you'. One relative wrote 'Can I also add a BIG thank you to the team who have been so supportive to (family member) during the last two weeks. He has been through such a lot and without the caring and kindness from staff he wouldn't have got through it. They are all wonderful people and me, and my family really appreciate everything they do'.

Relatives felt staff were caring. One relative talked about two staff who they felt went that extra mile. They said, "They (the two staff) just know their little ways". A relative told us "they (family member) as always happy and that's what counts. I can't fault the staff".

People and their relatives were involved in the initial assessments of people's support needs and planning their care. The registered manager told us at the time of the inspection people were able to make day to day decisions and were also supported by families or their care manager, and no one had needed to access any advocacy services. Details about how to contact an advocate were available within the service. Information given to people confirmed that information about them would be treated confidentially.

People received person centred care that was individual to them. People were supported by a small staff team, enabling them to be able to develop relationships with people and aid continuity and a consistent approach by staff.

Staff were knowledgeable about people, their support needs, individual preferences and personal histories. This meant they could base their support on things people enjoyed and were interested in, and ensure that support was individual for each person. Staff were able to spend time with people and throughout the inspection staff talked about and treated people in a respectful manner. Observations showed that staff understood people's body language and signs they made and responded to these. For example, one person was tapping their hand and staff told me this meant they wanted a cup of tea and they were supported to the kitchen and helped to make a drink.

One person showed us some photographs of their recent birthday party, which they had really enjoyed. Staff had supported them to organise this, which was a bar-be-que in the garden based on one of their interests. They had also chosen to go out for a pub lunch on the day of the inspection instead of their usual activity and been joined by two friends to celebrate their birthday.

Support plans contained details of people's preferences, such as their preferred name and in most cases information about their personal histories.

Relatives felt people were encouraged to be as independent as possible. One relative talked about how their family member did more now, "even if it is only little things like take their dinner plate away". One person told us they made their own drinks and helped staff prepare their meals. Staff told us people's independence was always encouraged. One member of staff talked about how a person had developed since they had known them, the changes had been very small, but significant to their development. They said at first the person did not really communicate with staff, but that now they were able to make their needs known. Observations confirmed this as the person was sitting in the kitchen watching staff starting to prepare their meal, they stood up and beaconed staff, the staff member responded immediately knowing that they wanted them to come with them, they led them to the toilet to show they needed support. This person was also supported to go food shopping and put things they liked into the basket something that would not have happened previously. They could also put away laundry with encouragement from staff.

Requires Improvement

Is the service responsive?

Our findings

People were involved in the initial assessment of their support needs and then planning their support. Relatives had also been involved in these discussions. Senior staff undertook initial assessments and additional information was obtained from health and social care professionals involved in people's support, to make sure they had the most up to date information about the person. People were able to 'test drive' the service by spending time, such as for meals getting to know other people they may live with and staff to ensure they were compatible. Following this a planning meeting was arranged with the local authority, staff and relatives. The support plan was then developed from these assessments, discussions and observations. In a recent quality assurance survey people indicated that they were involved in their care planning, one person commented 'by asking me what I like and don't like'. Another person said, '(Staff member) and (staff member) helped me with my plan'.

Support plans contained information about people's wishes and preferences. People had been involved in developing their care plan. Pictures and photographs had been used to make them more meaningful. Support plans should have contained details of people's preferred routines, such as a step by step guide to supporting the person with their personal care in a personalised way. This included what they could do for themselves and what support they required from staff. In some cases support plans were very clear about what people could do for themselves and what input was required by staff, but this was not consistent, to ensure people's independence was maintained or developed.

One support plan although had evidence of regular reviews contain out of date information as in several places it referred to a person that the individual no longer shared their home with and staff told us this had been the case for some time. The support plan also referred to staff using a 'picture format healthy eating support plan' that staff needed to follow. When we visited the person staff could not find this document and told us they no longer used pictures to support the individual with menu planning, but used objects of reference from the fridge or cupboards, but the support plan had not been updated, to ensure a consistent approach was always used.

Another support plan contained conflicting information to the person's health action plan. For example, in one it stated the person did not have capacity to make day to day decisions, but in the other it stated they did have this capacity. In the health action plan it stated that the person had 'sloppy' consistency of food based on advice from a health professional, but this was not mention in the eating and drinking support plan. According to the support plan this person was prescribed topical medicines to ensure their skin remained healthy, but applying these were not included in the personal care section of the plan. Information about the person dressing was confusing as it stated the person could dress themselves only later to say the person would need 'a little support', but did not detail what support that would be. Staff told us this person would dress themselves, but may need some verbal prompts. They went onto say that if the person was not going out that day and put something on the wrong way round for example, staff would not intervene as this did not matter and the person gained confidence, which was important from doing the task without staff intervention. However this was not mentioned in the support plan. After a shower the support plan stated to 'support me to wash/mop away the excess water and soap/bubbles and make sure it is clean

and hygienic ready for the next person to use'. However it did not detail what parts of this tasks the person could do for themselves and what staff would be required to do.

Another support plan stated that the person required one to one assistance with housework, but did not detail what the person could do for themselves and what staff would need to do. The support plan stated 'I like my meals at regular times', but there was no detail about what time the person preferred. The support plan stated that the person needed support to send birthday cards to their family, but the important date's section had not been completed to aid this. The health action plan stated that they had a cream for dry skin, but this was not mentioned in the personal care section. According to the health action plan they required support with their eye care, which senior staff confirmed in discussions, but again there was no detail of what support or when in their support plan.

The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not socially isolated as they were supported to attend groups and clubs and access the local community. People were supported to attend local church services and use local shops and pubs as well enjoy days out to places or attractions they were interested in.

One person told us if they were unhappy they would speak to senior staff based at their service. There had been no complaints in the last 12 months. There was an easy to read complaints procedure although people would probably be supported to express their concerns. The registered manager told us any complaints would be used to learn from and improve the service.

People had opportunities to provide feedback about the service provided. Quality assurance questionnaires were sent out annually to people, their relatives, professionals and staff. The latest results for May 2016 results had been collated. These showed that people were happy with the support they received.

Good

Is the service well-led?

Our findings

The registered manager's job title was an operations manager and there were two operations manager to cover the Kent area, who both worked four days a week. They were supported by five support managers and six team leaders. At the time of the inspection there was a vacancy for one support manager. Support managers and team leaders were based out in the community where they had an office in a shared home or block of homes. The support managers were responsible for people's support plans and review meetings, organising their support, staff supervision and monitoring their training. In addition there was an administrator based at the location.

Staff said of the registered manager that they "had a good understanding of people they supported and they made people feel comfortable when they visited". Staff said about senior staff and management they "Work as a team and communication had got better".

A social care professional told us "The service is excellent" and the registered manager "is passionate about her role and a good leader".

In recent quality assurance surveys professionals were complimentary about the service. Comments included, 'Communication is outstanding, I have a particularly good relationship with staff'. 'Person centred, individualised support. Good management, communication and information sharing'. 'Support is generally of a good standard'.

Relatives felt the service was well-led and well organised. One relative said, "They do their best to ensure they have a happy life". Relatives said the communication with staff was good as they always responded to their questions.

Staff said they understood their role and responsibilities and felt they were well supported. They had team meetings, supervisions and handovers where they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns. The provider had also organised staff forums as a result of feedback from staff. These were meetings chaired by the regional director where staff could discuss concerns and give feedback about current working. For example, sickness, working times/shifts, survey results, training, mental capacity and staff leaving. Induction training had been reviewed recently and changed as a result of feedback from staff. Staff told us "There was flexibility for each service". This had not always been the case, but the provider was "getting better at that". A staff health and safety forum was also held regularly looking at incidents, accidents, any medicine errors and health and safety checks.

Audits were carried out to monitor the quality of the service and to identify how the service could be improved. This included the operations managers visiting people regularly in their own homes and speaking with them, undertaking observations of staff practice, discussions with staff and checks on records including their support plans. An annual quality audit was also carried out by the operations manager and this looked more in-depth at the outcomes a person was receiving and their records, where shortfalls were identified an

action plan was put together and monthly updates were received from support managers. Training and supervision data reports were sent to the operations managers monthly for monitoring. The provider had set various key performance indicators, which the operations managers had to meet. These included training, supervision and team meetings, DBS's, staff probation meetings, support plan and other care document reviews, financial checks, health and safety checks and service visits. If 100 percent was not achieved then an action plan was developed and monitored.

The registered manager attended regular managers meetings, which were used to monitor the service, keep managers up to date with changing guidance and legislation and drive improvements and learning.

The provider was working to achieve an Autism Accreditation for some of the services in Kent. One service already had this accreditation. The registered manager told us this included undertaking a self-assessment, which had commenced and they had already recognised where further improvements within the service could be made, including changes to care planning to further aid independence and work towards less staff input. The registered manager told us that new support plans were being developed and training was planned for later in the year.

The provider had achieved Investors in People accreditation. Investors in People have set standards for better people management, which providers have to meet. The provider had also signed up for the Driving Up Quality Code, signing up is a commitment to driving up quality in services for people with learning disabilities. The registered manager told us this had impacted on the service by quality assurance systems focussing on outcomes for people and people being supported to be more involved in their local communities. The provider had signed up to the Kent Challenging Behaviour Network. This is an online facility that aims to promote and share best practice.

The provider had a mission statement to enable people with learning disabilities to pursue active and fulling lives, gain increased independence and achieve equal rights as citizens. Staff were aware of these and demonstrated during the inspection that they followed these through into their practice.

People, their relatives and social workers all completed quality assurance questionnaires to give feedback about the services provided. Responses on the whole had been very positive. An action plan was in place to address the negative comments.

Staff had access to policies and procedures within their offices. These were reviewed and kept up to date. Records were stored securely and there were minutes of meetings held so that staff and people would be aware of up to date issues within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. Regulation 9 (3)(b)