SignHealth

Sign Health London Outreach

Inspection report

The Bridge, Falcon Mews
46 Oakmead Road
Balham
SW12 9SJ

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07 June 2016
13 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 and 13 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our previous inspection on 17 October 2013 we found the provider was meeting the regulations we inspected.

SignHealth Outreach provides personal care and supports deaf people to lead independent lives. They support people across the whole of London. All of the outreach workers that support people are either deaf or fluent in British Sign Language (BSL). At the time of the inspection, the provider was supporting approximately 20 people ranging from a few hours a week to more intensive support very day.

There was a registered manager at the service. 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 told us that they felt safe in the company of care workers. They told us they would not hesitate to speak with the registered manager or staff if they were worried about anything. They told us they led independent lives and were able to take part in activities and pursue their own interests. Some people went to college, others went to the gym and attended deaf club.

People were supported in their daily living activities with the appropriate level of staff support. The people we spoke with lived in individual flats in a shared home. They all did their own shopping, prepared their own meals and took their own medicines. They said they were all confident in carrying out these tasks but staff were always there to help them if needed. Staff gave guidance and prompted people and made sure they had what they needed.

Staff communicated effectively with people using the service in British Sign Language (BSL). All the staff were BSL trained and the provider also made use of technology to enable more effective communication with deaf people and staff, using video calls via Skype to speak with them.

Care plans included risk assessments and support plans that were individual to people. Care records were written in plain English and the provider made use of pictures to help people understand them better. Care records were signed by people, indicating their agreement to their content.

The provider had thorough recruitment checks in place which helped to ensure care workers were suitable to work with people. This included taking references, identity and criminal background checks.

Caregivers completed an induction programme which included going through the role, an introduction to the organisation and completing some shadowing shifts with experienced care workers.

Although on-going training was provided, this was not tracked effectively so we could not be assured about the level of training that care workers received.

There was an open culture at the service. The registered manager took time speaking to people and staff and made himself available either visiting people in their homes or by video calls.

Although care records were reviewed regular and checks were carried out in people's homes, there was a lack of formal quality assurance from a management perspective. Some of the quality assurance audits had not been carried out recently. Other audits such as feedback surveys were completed for the provider but the results were difficult to narrow down to the service we inspected.

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 using the service told us they felt safe living in their accommodation and if there were any problems, they would speak with staff.

Individual and environment risk assessments were in place which helped to keep people safe.

The provider had recruitment checks in place which helped to ensure appropriate staff were employed.

People using the service told us that they managed their own medicines with appropriate staff support.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

On-going training for staff was not monitored effectively, making it difficult to know whether they received regular training.

People using the service told us they were not restricted from leaving the service and were able to lead independent lives.

Care plans were signed by people, indicating their consent to their content.

People's health and diet support needs were met and by the provider.

Is the service caring?

Good

The service was caring.

People lived in shared accommodation that allowed them privacy but also helped to enhance their social skills.

Care records were written in clear, plain English and made use of pictures which helped to make them more accessible to people.

Is the service responsive?

Good

The provider supported people to take part in activities in the community and encouraged them to maintain hobbies and interests.

Care workers completed comprehensive review reports which were used by other professionals when reviewing people's care.

People using the service told us they would speak to staff if they were not happy with any aspect of the care and support they received.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

There were no recent audits carried out to monitor the quality of the service.

There was an open culture at the service and the registered manager was available to support staff and people.

The provider was proactive in raising awareness around dementia within the community.

Sign Health London Outreach

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 7 and 13 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector who was supported by a British Sign Language (BSL) interpreter so that we could speak with people using the service and staff.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with four people using the service and three staff members including the registered manager. We looked at records including four care records, training records, three staff records, and audits.

After the inspection, we contacted 14 health professionals to gather their views and received responses from four of them.

Good

Is the service safe?

Our findings

People using the service told us they felt safe living in their accommodation and if there were any problems, they could call on care workers. They said "I feel safe, everything is checked" and "We can call them (staff) on the emergency phone if there are problems."

Care workers were familiar with safeguarding procedures and training records showed they had received training in this area. Some of their comments included, "If there was abuse, like financial, we would inform the safeguarding team or the social worker. Any investigation will be done by them", "The first port of call will be [the registered manager]", "Yes we had training in safeguarding." They were also able to tell us how they would identify any concerns, "We monitor their behaviour. If something is unusual in their behaviour patterns, anything out of the ordinary."

A safeguarding and whistleblowing poster was on display in the office and in the home we visited, advising staff and people who they could contact if they were worried that someone was at risk. There had been no incidents of a safeguarding nature with the provider since the last inspection.

Risks to people were managed effectively and staff were provided with appropriate guidance on managing risks to people which helped to ensure they were safe.

Staff told us they carried out regular risk assessments, they said, "Yes we would do risk assessments, risks around behaviour. We communicate with the social work team if we have to and do any monitoring" and "The initial assessment includes a thorough risk assessment."

Risk assessments were current and individual for people using the service. Some of the identified risks that we saw for people included medicines, food expiry and washing. Each identified risk listed the staff support needed to minimise the risk and prevent harm to people. An agreed plan was in place between the provider and people to manage the risk. These were signed by people using the service.

People's homes were risk assessed which helped to ensure the environment was safe. We saw current certificates related to health and safety such as Portable Appliance Testing (PAT) certificates and fire safety maintenance records. Regular fire checks were also conducted and maintenance and emergency contact numbers were available if needed.

The provider had thorough recruitment checks in place which helped to ensure appropriate staff were employed.

The provider had a policy in place to renew care workers Disclosure and Barring Service (DBS) checks every three years. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Recruitment checks included written references on people's suitability for a position as a care worker and DBS checks. The provider kept a spreadsheet of all staff DBS numbers which were all current.

The registered manager talked us through the process of recruiting new staff. Potential care workers were invited in for an informal chat to assess their suitability for the role. He told us they were usually given advice about any extra training they needed and whether their British Sign Language (BSL) competency was at the required level.

People using the service told us that they managed their own medicines but with some staff support which included asking them if they had taken it and checking their medicine administration record (MAR) charts were completed accurately if they were in place. Some of their comments included, "I take my medicines myself", "Staff ask us if we have taken our medicines", "I have a weekly chart with my medicines on it" and "I have a prescription, I go once a month."

People using the service showed us their medicines which they kept in their homes and we checked that they were taking them as directed.

Easy read information leaflets were also available for staff to familiarise themselves with the uses of medicines and their side effects. There was also a medicines policy in place which gave guidance on the how people could be supported to take their medicines safely. One care worker said, "I support a person with deteriorating dementia. I check [their] medication, make sure [person using the service] has his/her tablets and get his/her prescriptions."

People's care records included a list of current prescribed medicines. We saw one example where a medicine dose had been reduced but the current medicines list was not updated. We told the registered manager about this who addressed it immediately.

Requires Improvement

Is the service effective?

Our findings

The provider had their own induction pack which covered eight areas including the organisation, the job role, personal development, communication, equality and diversity, duty of care, principles of safeguarding, and health and safety. The registered manger told us the organisation was looking to incorporate the Care Certificate as part of the induction of new staff but this had not been done at the time of our inspection. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers was developed jointly by Skills for Care, Health Education England and Skills for Health.

New care workers spent a day in the office going over policies and procedures and then shadowed a more experienced care worker which helped them to familiarise themselves with the practical aspects of the role. A member of staff told us, "I've had first aid training, we normally do about two training courses per year."

We found that the ongoing training of staff was not monitored effectively which meant that we could not be assured care workers received an appropriate level of training to meet people's needs. The provider had a training matrix to track the training that staff had received but this was not up to date. The registered manager said some care workers had completed training courses with other organisations and any training they had completed with them was considered when looking at their training needs. However, he said not all the information had been uploaded onto the matrix. In the staff files that we saw, some training certificates were seen in individual files which were not reflected in the matrix.

The Mental Capacity Act 2015 (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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community services are to be made to the Court of Protection.

A Deprivation of Liberty Safeguards (DoLS) queries flowchart was on display in the office, providing staff with guidance on how to manage queries regarding DoLS. Reference was made about the distinction between residential and supported living services and applications needed to be made to the court of protection in the case of supported living services.

People using the service told us they were not restricted from leaving the service and were able to lead independent lives. All of the people using the service had an understanding of their care needs and the level of support they needed. There was evidence that people were involved in the support they received. Care plans were signed by people, indicating their consent.

Care workers told us if there were any indications that people were not able to consent or understand any decision related to their care they would speak to the registered manager or their care co-ordinator.

They also told us they always offered people a choice and respected their decisions if they refused any help. One care worker said, "If people refuse personal care then their choice will be respected. However, you have to balance this out and if they refuse for a number of days then it may mean they are being neglected."

People were in control of what they ate and managed their meals independently with an appropriate level of staff support. They told us, "We all do our own food shopping", "I cook my own meals" and "I make my own breakfast. Sometimes I go out to eat."

Care workers told us, "[Person using the service] is capable of making his/her own meals, I just have to prompt [them]" and "I ask them if they have eaten, we also check the fridge to make sure the food is OK." If people had specific support needs in relation to nutrition then these were recorded in their care records. This included details about preferences and the level of support required.

The provider engaged proactively with health and social care agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services if required such as the GP and other services.

A person using the service told us, "Very helpful, [the care worker] takes me to appointments." Care workers told us, "All care records have all the details of who to contact in case of an emergency" and "We regularly discuss any concerns about people's health with [the registered manger] and then he will link up with the care co-ordinator."

Care records included people's diagnosis, their medicines, details of their CPN, psychiatrist, keyworker, GP and a list of stakeholders.

We saw evidence that people were supported to attend Care Programme Approach (CPA) meetings. The CPA is the framework for providing care to adults with mental health problems and people with learning disabilities who also have mental health problems. It is the way of assessing their needs and planning the best way for health and social care services to ensure that people's needs are met.

Health and social care professionals that we contacted told us they were kept informed by the provider about any changes to the health or wellbeing of the people using the service. They said the provider worked well with them and provided valuable input which they found useful when supporting people.

Good

Is the service caring?

Our findings

People using the service told us, "Staff don't interfere, its relaxed here", "I'm happy", "Staff are helpful" and "I enjoy living here more than my previous home."

People lived independent lives and in the service we visited, lived in self-contained one bedroom flats with their own kitchen and bathroom. They shared a communal living space and garden. This meant that people had the privacy that they needed but at the same time were able to live in shared accommodation with people which helped to enhance their social skills. They all told us they enjoyed each other's company and in some cases, they attended activities such as going to the gym together. When we spoke with them, it was evident that they were comfortable with each other and there was mutual respect between them.

The registered manager told us they always tried to match people with care workers who shared similar interests and based on their needs. This was supported by feedback we received from health and social care professionals who told us that it was important for some people to have the right kind of staff because of their mental health needs and the provider was always considerate in this regard and was good in matching staff with people using the service.

Staff told us that the support they provided to people varied from a few hours a day or a few times a week, to every day throughout normal working hours. They told us that each person was different and required varying levels of support. They said, "I prompt and encourage him/her to brush his/her teeth, have a shower" and "I check all medicines, check letters and arrange appointments." People were encouraged to maintain their independence with respect to their daily living skills.

People's preferences were also documented including how they liked to live their life and activities they enjoyed. People said they were supported to maintain important family and social relationships, telling us, "I go visit my family" and "I spend Christmas with friends."

Care records were written in clear, plain English and made use of pictures which helped to make them more accessible to people. Care records were written in a way which encouraged care workers to support people's independence. For example, where people were identified at risk of poor personal hygiene or the cleanliness of their rooms, guidelines were in place for staff to encourage and support them to improve on this aspect. They were given specific instructions on ways to encourage people and these were reviewed regularly. One person told us, "We all share the housework."

Staff communicated effectively with people using the service, regardless of their level of competency in British Sign Language (BSL). All the staff were BSL trained and people who had basic BSL skills were encouraged to attend courses to improve their level of communication. The provider also made use of technology to enable more effective communication with deaf people and staff, using video calls via Skype to speak with them. This allowed them to discuss any issues while they were supporting people in a timely manner. We saw this in practice during the inspection.

Good

Is the service responsive?

Our findings

People were able to lead independent lives and access the community which helped protect them against the risks of social isolation and loneliness. The provider helped people when they wanted to take part in activities in the community and encouraged them to maintain hobbies and interests.

People using the service told us, "I go out for walks", "I was at college yesterday" "I go for BSL and computer literacy" and "I go gym once a week." They said they received appropriate staff support if they wanted to explore new activities.

The registered manager dealt with any referrals that were received and carried out an assessment with a liaison officer to see if the person's needs could be met. The office administrator looked at whether there were enough care workers with the appropriate competency to meet people's needs such as availability of hours, travel time and any specific requirements. During the initial assessment, the registered manager told us he asked people what their needs and expectations were. Care plans were developed and shared with people, "When we review the care plans, we ask people. We work in partnership with them." The assessment process was individual to each person, with some people requiring more thorough assessments than others.

Pictorial care plans were provided for people who were not able to understand written documents easily. Easy read tenancy agreements were also available. The registered manager said, "The records are modified and adjusted according to the client's needs. We also use certain software applications to help develop care plans."

Care workers completed comprehensive review reports covering a range of topics such as domestic skills, activities, general health, diet, finance, hygiene, community skills, medicines and communication. These reports were used for Care Programme Approach (CPA) meetings in order to provide an overview of how people were coping with these areas. We saw that any areas that people needed additional support with were incorporated into support plans.

Care workers also completed monthly reports about people they supported which gave a detailed narrative on people's wellbeing over a month.

Care records were split into personal details, support plans, needs assessments, risk assessments, meetings reviews, health appointment records and correspondence from professionals. Support plans were based around aspects of daily living and were reviewed regularly. In some of the care plans that we saw, it was difficult to see how much support had been provided to each person. For example, some people needed support with personal hygiene and budgeting and they had support plans in place for this. However, in the reviews that we read, which were at six month intervals, it was difficult to get a sense of what had been achieved between the two review dates.

People using the service told us they would speak to staff if they were not happy with any aspect of the care and support they received. They said there was always someone available to speak with, either through the care workers that came to support them or speaking with someone in the office.

There had been no formal complaints received in the past year. There was a complaints policy in place which was also available in a pictorial and easy read format. This gave details of timescales to receive an acknowledgement and a full response and different ways in which complaints could be raised.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance checks in people's homes were in place such as checks on the environment and ensuring care plans and risk assessments were reviewed on a regular basis. Monthly reports were also completed for each person. However, we found that there was a lack of monitoring from a management perspective. For example, although quality assurance forms were in place, the registered manager was unable to find any recent visits. The last internal service audit that was shown to us was from 6 October 2014. These were based around the old CQC inspection methodology. The registered manager also told us that a manager from the head office had been "around 6 months ago" but was unable to find the report they had completed.

Feedback was sought from stakeholders, these were sent directly from head office in July 2015. However, the registered manager told us but there had been a low response rate and the results had not filtered down to him. He told us that the responses received were not specific to the service he managed but for every registered service therefore it was difficult to draw out any conclusions from it or enable any learning.

Sign Health London Outreach help deaf people to lead independent lives. The vision mission and aims and values were displayed in the office for staff to refer to. The aims and values included person centred care, involving, enabling, expert, respect and safeguarding. Health professionals we contacted gave us feedback which indicated the provider was striving to achieve these aims. They told us the service met peoples' individual needs, they were kept up to date about any changes to people's support needs, and said that staff were knowledgeable and that the organisation was professionally run.

We saw that the registered manager was heavily involved in the running of the service. Throughout the inspection, if there were any issues that needed resolving he was available to provide support either on the phone or in person. He was familiar with people's support needs, we observed him speaking with people in their homes and they were comfortable in expressing their views to him.

There was an open culture within the service. Staff that we spoke with were positive about the management and leadership of the service. They told us that the registered manager was approachable and available to speak with at any time. Care workers came to the office throughout the inspection either to catch up on paperwork or speak to the office staff. They told us, "I really do enjoy it" and "Our team works together very well."

Team meetings were held on a regular basis, some of the areas discussed included discussing new people to be supported, holidays and staff rotas. Staff told us "We have a chat and catch-up every morning" and "We do have team meetings, we discuss any issues that need to be brought up."

Residents meetings were also held monthly. These were open forum and people were given the opportunity to discuss any issues that were relevant to them. We reviewed the minutes of these meetings and saw that the provider was responsive to people's requests and had been acted upon them and followed them up at subsequent meetings.