At Home in the Community Limited

At Home in the Community

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This was an unannounced inspection carried out over three days on 10 July, 17 July and 30 July 2015.

We last inspected At Home in the Community in December 2013. At that inspection we found the service was meeting all of its legal requirements.

At Home in the Community is registered to provide personal care to adults with learning disabilities. People are supported by staff to live individually in their own homes or in small groups, referred to as independent supported living schemes. Different levels of support are provided over the 24 hour period dependent upon people's requirements. Many of the people are tenants of their home and pay rent for their accommodation which is leased from housing associations.

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

Summary of findings

People told us they felt safe. They were relaxed and appeared comfortable with the staff who supported them. One person said, “The staff keep me safe, I trust them.” Another said “I go out shopping with staff but I can go to the local shop on my own.”

People received their medicines in a safe and timely way. People who were able, were supported to manage their own medicines. One person said, “They make sure I take my medicines.”

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and “best interest decision making”, when people were unable to make decisions for themselves. People who had capacity told us staff asked their permission when providing care and support.

Staff told us they received regular training, supervision and appraisal so they were knowledgeable about their roles and responsibilities.

People who used the service had food and drink to meet their needs. Some people were assisted by staff to plan their menu and cook their own food. Other people received meals that had been cooked by staff.

People had access to health care professionals to make sure they received appropriate care and treatment.

Staff knew the people they were supporting well. Care was provided with patience and kindness and people’s privacy and dignity were respected.

Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care. The records gave detailed instructions to staff to help people learn new skills and become more independent.

People told us they were supported to go on holiday and to be part of the local community. They were provided with opportunities to follow their interests and hobbies and they were introduced to new activities.

People were supported to maintain some control in their lives. They were given information in a format that helped them to understand if they did not read to encourage their involvement in every day decision making.

People had the opportunity to give their views about the service. There was regular consultation with staff, people and/ or family members and their views were used to improve the service.

A complaints procedure was available and written in a way to help people understand if they did not read. People we spoke with said they knew how to complain.

The provider undertook a range of audits to check on the quality of care provided.

Summary of findings

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 in a safe and timely way.

Staffing levels were sufficient to meet people's needs safely and flexibly and appropriate checks were carried out before staff began work with people.

People were protected from abuse as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Positive risk taking was encouraged as people were supported to take acceptable risks to help promote their independence.

Is the service effective?

Good

The service was effective.

People received individual care in the way they wanted as staff had a good understanding of their care and support needs. Where people were unable to give consent, staff were aware of and followed the requirements of the Mental Capacity Act 2005.

Staff received the training they needed to ensure people's needs were met effectively, and were given regular supervision and support.

People received appropriate support to meet their healthcare needs. Staff liaised with GPs and other professionals to make sure people's care and treatment needs were met.

People were supported to eat and drink according to their plan of care.

Is the service caring?

Good

The service was caring.

Relatives and people we spoke with said staff were kind and caring and they were very complimentary about the care and support staff provided.

People were offered choice and staff encouraged them to be involved in decision making whatever the level of support required.

People's rights to privacy and dignity were respected and staff were patient and interacted well with people.

Staff supported people to access an advocate if the person had no family involvement. Advocates can represent the views of people who are not able express their wishes.

Is the service responsive?

Good

The service was responsive.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver people's care. Care plans were in place and up to date to meet people's care and support requirements.

Summary of findings

People were provided with a range of opportunities to access the local community. They were supported to follow their hobbies and interests and were introduced to new experiences.

People had information in a format they may understand to help them complain.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place who promoted the rights of people with a learning disability to live a fulfilled life within the community.

An ethos of involvement was encouraged amongst staff and people who used the service. Staff and people who used the service said communication was effective.

The registered manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

At Home in the Community

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.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care. We spoke with the local safeguarding teams. We did not receive any information of concern from these agencies.

This inspection took place on 10 July, 17 July and 30 July 2015 and was an unannounced inspection. It was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service for people with a learning disability. During the inspection the inspector visited the provider's head office to look at records and speak with staff and after the inspection the inspector visited three people who used the service to speak with them and the staff who supported them. An expert by experience carried out telephone interviews with some people who used the service and some relatives.

As part of the inspection we spoke with six people who were supported by At Home in the Community staff, four relatives, four support workers, the registered manager and operational manager. We reviewed a range of records about people's care and checked to see how the schemes were managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits that the registered manager completed.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. People commented, “I know my carers and trust them,” and, “My carers keep me safe.” Relative’s also confirmed people were safe. They told us, “(Name) is safe. I trust the carers. I know them and I can ring them on their mobiles if I need to,” “I think (Name) is safe with the carers. They turn up on time, sometimes they’re a bit late but they tell us before if they’re going to be late,” and “(Name) wouldn’t go out with the carers if they weren’t happy to.”

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider’s whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. They told us, and records confirmed they had completed safeguarding training.

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found concerns had been logged appropriately. Safeguarding alerts had been raised by the service and investigated and resolved to ensure people were protected. One safeguarding incident with regard to financial abuse was still being investigated by the police. The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities or independent investigations were carried out. Where incidents had been investigated and resolved internally information had been shared with other agencies for example, safeguarding.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. Examples included, “I need staff to support me to prepare and cook my food,” “I do not use knives as I could cut myself,” and “I need plenty of drinks with my food as I am afraid of choking.” Our discussions with staff and people who used the service confirmed that guidance had been followed.

A personal emergency evacuation plan (PEEP) giving guidance if the house advice needed to be evacuated in an emergency was available for each person. They took into account people’s mobility and moving and assisting needs. PEEPs were reviewed monthly to ensure they were up to date. People we visited told us they were involved in carrying out the weekly health and safety checks around the house with staff. They also took part in fire drills so they knew what to do in case of fire.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the registered manager so that appropriate action could be taken. For example, an incident form had been submitted for a person who had experienced an epileptic seizure. This was reviewed by a manager at the office, together with the person’s care plan, to check the necessary action had been taken and that other appropriate professionals were involved to give advice and treatment.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker’s competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. The registered manager told us any reported medicine errors were reviewed and action was taken to strengthen and help protect people with regard to medicines management.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required. Staff worked in small teams with people they supported so the person became familiar with all the staff. As the service supported people to learn new skills and to become more independent in activities of daily living a person might over time require less staff support.

Good

Is the service safe?

People and staff had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. Staff members commented, "Someone is always available," and, "We have the on call telephone number." A person who used the service also said they had the telephone number to contact staff if they needed to.

Staff had been recruited correctly as the necessary checks to ensure people's safety had been carried out before people began work in the service. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included, "I like working for the organisation, there's plenty of training," "I would like to do a sign language course," "My training is up to date," and "I get opportunities for training."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of work books, face to face and practical training. The registered manager told us new staff completed a twelve week induction and studied for the new Care Certificate in health and social care as part of their induction training.

The staff training records showed staff were kept up-to-date with safe working practices. The registered provider and registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as epilepsy awareness, dementia care, conflict resolution, communication, mental health awareness, care planning, professional boundaries and equality and diversity. The staff training matrix showed management courses were also provided to staff who had managerial responsibilities.

Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. They said they were well supported to carry out their caring role. One person told us, "I receive supervision every two months." Staff said they could also approach the registered manager and other managers in the service at any time to discuss any issues. They also said they received an annual appraisal to review their work performance. This was important to ensure staff were supported to deliver care safely and to an appropriate standard.

CQC monitors the operation of the Mental Capacity Act 2005(MCA). This is to make sure that people are looked after in a way that does not inappropriately restrict their freedom and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. The registered manager told us an Independent Mental Capacity Advocate(IMCA) had become involved, as required by the MCA, because a person without capacity had needed some dental treatment and the IMCA had worked with the person, the dental hospital and staff who supported the person.

The registered manager was aware of a supreme court judgement that has clarified the meaning of deprivation of liberty so that staff would be aware of what processes to follow if they felt a person's normal freedoms and rights were being significantly restricted. Within the Independent Supported Living (ISL) houses some people did require constant support to keep them safe. The registered manager was aware the deprivation of liberty process was not applicable within the supported living environment as people were tenants in their own house therefore advice was being taken from the local authority about the Court of Protection process. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity.

People using the service were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

The registered manager told us they worked with the local authority to ensure appropriate capacity assessments were carried out where there were concerns regarding a person's ability to make a decision.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. One relative commented, "It takes a while for new carers to understand (name) but eventually they do."

People told us care workers always asked their permission before carrying out any tasks. At home visits we saw care

Good

Is the service effective?

workers checked the person was happy for them to proceed as they provided support to the person. We saw people's care records contained signed consent forms, and that care plans and contracts were signed by them or their representatives to keep them involved.

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. People required different levels of support. Some people received support from staff to help them plan their weekly menu. They would then be supported by staff to shop for their food and help prepare or make their own meals and drinks. One relative told us, "(Name) is supported to prepare their own meals. (Name) eats 'ready meals'. I would like (Name) to do more cooking. I've mentioned it to the manager." One person's care plan stated, "If I want to help in the preparation of my meal, I will get the ingredients, chopping boards and cooking utensils from the cupboard or fridge." People commented, "I go shopping on Thursday for my food but I go out for meals as well," "I plan a menu with staff every week," and "I help to cook my food." Some people had specialist needs regarding how they received their nutrition and staff received guidance and support to ensure these needs were met.

People who used the service were supported by staff to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from GPs, opticians, dentists, speech and language therapists, nurses and other personnel. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. Written guidance was available for staff with regard to people's support requirements. For example, "I require staff support to book health appointments for me." "I require extra support and reassurance around the dentist as I have a phobia about the dentist. I don't even like to talk about it as I become anxious." One person commented, "I've had a check-up at the doctors and my carers took me to the dentist." A relative told us, "When I was on holiday and (Name) was unwell, carers supported (Name) to visit the doctor."

Good

Is the service caring?

Our findings

People spoke positively and spoke well of the care provided by staff. They told us staff were kind and caring. Comments included, "I like the staff," "The staff are kind," "Staff listen to me," "Staff ask me what I want to do," and "I think the staff care." Some relatives commented, "Staff have a nice attitude," "They talk to (Name) in a way that is appropriate. They are (Name)'s support and confidante," "Staff are very patient," "(Name) can't tell us but we know (Name) likes them," and, "I'd know if (Name) wasn't happy." A relative also told us, "They also support me in a quiet way. If I'm not well, I can tell they're quietly assessing the situation."

People who used the service were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. People who were able to talk to us about their experiences said they were happy with the care and support they received. During the inspection we saw staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. We saw pictures were available to help people make a choice with regard to activities, outings and food.

People told us they were involved and kept informed of any changes within the organisation and staff kept them up to date with any changes in their care and support. Information was made available in a way to promote the involvement of the person. For example, by use of pictures or symbols for people who did not read or use verbal communication. We saw evidence of this with the complaints procedure, the fire procedure, the information guide given to people when they started to use the service, assessments and care records. Everyone had a communication passport that provided information about the person and advised staff how people communicated. For example, "I can communicate through gestures," "I need staff to listen carefully to what I am saying as my speech can be unclear at times," "facial expressions," and "body language."

People were encouraged to make choices about their day to day lives. Care records detailed how people could be supported to make decisions. One stated, "I can make my own decisions when given visual choices." People told us they were able to decide for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. People told us, "It's up to me, it's my choice what we do," "I choose where I want to go," and, "Staff help me look after my money and they help me shop. It's my choice where we go." A relative commented, "(Name) chooses where they want to go, staff ask (Name). At one time, they were going into town all the time. I told the manager and she got carers to find out where else (Name) would like to go."

The registered manager had identified that people's care records should document the end of life wishes of people, and their family, with regard to their wishes. This included people's spiritual requirements and funeral arrangements and who they wanted to be involved in their care at this time.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. We saw staff knocked on a person's door and waited for permission before they went into their room. Another staff member respected the fact a person liked to spend time on their own, as they received 24 hour care, and they told us they sat in another room for part of the evening.

The registered manager told us an advocacy service was involved where a person needed to have additional support whilst making decisions about their care. An advocate was also involved where people had no family support. We saw a recommendation from an advocate where they had written to the registered manager to draw attention to some one's shopping routine. Reference was made to the use of advocates in the information guide given to people who used the service.

Good

Is the service responsive?

Our findings

People and relatives said they were supported and involved in planning their care. Comments from people included, "When At Home in the Community first started to provide support, they talked with me and my relative about what help I needed," and, "I have a meeting with my support worker to talk about my care and see how things are going." Some relatives commented, "When (Name) started using the service about two years ago we talked with the manager and social worker. I know (Name) has a support plan," "The manager came out to talk about (name)'s needs to see what support was needed," "(Name)'s care plan has not been reviewed recently but I had a phone call to say it is going to be reviewed," "(Name)'s care is reviewed annually and I'm asked to contribute," and "(Name) is encouraged to do as much as they can for themselves."

Assessments were carried out to identify people's support needs and care plans were developed that outlined how these needs were to be met. Care plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. A relative told us, "(Name) is encouraged to do as much as they can for themselves. When they go swimming staff encourage (Name) to get dressed by themselves as much as they can." Care records provided a description of the steps staff should take to meet the person's needs. For example, "I spend time alone in my house approximately four hours each day. Guidelines are in place which staff and I am aware of," "Staff should support me to fill in a decision planner. If I choose not to attend a social event do not try and persuade me as once I have made my mind made up I will probably not change it," "I require support to fill the bath and ensure water is at a suitable temperature. I need support to wash my hair and my back. I attend to the rest of my personal care requirements," and, "I can travel independently by bus and I have a bus pass."

Detailed records were in place for the management of some people who displayed distressed behaviours. These people had care plans to show their care and support requirements when they were distressed. The care plans gave staff guidance with regard to supporting people. Information was available that detailed what might trigger the distressed behaviour and what staff could do to support the person.

Staff rosters showed there were sufficient staff available to meet people's individual needs and to support them to pursue their interests and hobbies. People told us they were supported to go to work, attend college or day placements and evening classes if they wanted. They said they were supported to try out new activities as well as continue with previous interests. For example, cookery classes, concerts, football, meals out, college, going to the gymnasium and computer classes. People commented, "I go shopping and to the café, I also like going to the coast and to the quayside," "I go to Sound." (Sound is a music resource where people meet and create sound and music.) "I go to the library to use the computers, "I like going out," "I go to the shop to buy my paper," "I don't watch television as much as I used to," "I go to work two days a week," and "I like shopping and sitting in the garden." Relatives commented, "(Name) goes swimming, and to college three days a week to do cookery," and "They take (Name) out shopping or walking, its' (Name's) choice."

People were supported to holiday in this country or abroad supported by staff. One person told us they were saving up to go to Spain for a special birthday in a couple of years. Another person told us, "I've been to Blackpool and Disney Land, I choose which staff go with me."

Staff at the service responded to people's changing needs and arranged care in line with people's current needs and choices. Records showed regular meetings took place with people. Weekly meetings took place to discuss each person's menu and activities for the following week and monthly meetings took place to review their care and support needs and aspirations for the following month. We saw that staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People had a copy of the complaints procedure which was written in a way to help them understand if they did not read. A record of complaints was maintained. Three

Good

Is the service responsive?

complaints had been logged and investigated in 2015. Monthly support worker meetings with people showed people were asked if they had any concerns about the support they received. Staff meeting minutes also showed the complaint's procedure was discussed with staff to remind them of their responsibilities with regard to the reporting of any complaints.

People said they knew how to complain. They said they would talk to staff and could raise any issues at the tenant's meetings or their planning meeting if they wanted.

Comments included, "I'd speak to staff if I was worried," and, "It's good (the service), but if there was a problem, my support worker (Name) would sort it out." Relatives commented, "I rang the manager the other day as (Name)'s carer had started to come too early. It was addressed straight away," "I've no complaints with the manager or staff. There's not really anything that could be improved," and "I've only had one issue when I didn't think the care worker was doing the job properly. I spoke to the manager about it, and it got sorted."

Good

Is the service well-led?

Our findings

A registered manager was in place. They had become registered with the Care Quality Commission in 2013.

The registered provider promoted an ethos of involvement and enablement to keep people who used the service involved in their daily lives and daily decision making. We saw a staff member had commented in a recent staff survey, "It may be natural to care but I see myself as a support worker more enabling people to do things rather than doing things for them." The culture promoted person centred care, for each individual to receive care in the way they wanted and to be helped to maximise their potential. Staff were made aware of the rights of people with learning disabilities and their right to live an "ordinary life." Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

Staff and relatives spoke positively about the registered manager and the organisation. They said they felt well-supported. Comments from relatives included, "I've got no issues with At Home in The Community, they've been excellent," "They give an excellent service, 10/10," "I cannot fault them. With the problem of (Name) attending college, they're prepared to change things (staff rosters) to meet (Name)'s needs," "Things are going alright. I can always pick up the phone to the manager. They're easy to talk to," and, "I'm quite happy. If I'm not happy about anything I don't hesitate to pick up the phone."

Staff told us they thought communication was good and they were kept informed. Staff who provided 24 hour support to people told us they received a handover from the staff member at the change of duty. This was to make them aware of any changes and urgent matters for attention with regard to the person's care and support needs. A communication diary was also used to pass on information and recorded any actions that needed to be taken by staff.

We saw records that showed staff meetings were held with the registered manager and all staff every three months. Staff also attended monthly team meetings chaired by the team leaders of individual households Staff could give their views and contribute to the organisation's running. Areas of discussion included, staff performance, health and safety, safeguarding and support worker duties.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of weekly, monthly, quarterly and annual checks. They included health and safety, infection control, training, care provision, medicines, personnel documentation and care documentation. Audits identified actions that needed to be taken. The annual audit was carried out to monitor the safety and quality of the service provided.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw surveys had been completed by staff and people who used the service in 2014 and findings were positive. The results were analysed by head office and we were told any action would be taken as required to improve the quality of the service.