United Response

United Response - Derwent DCA

Inspection report

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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 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included one inspector. Telephone calls were made to staff, family members and other professionals between 13 and 23 February 2017.

At the time of this inspection, United Response Derwent DCA provided support to 17 people in their own homes. This inspection covered services provided for seven people who received the regulated activity of personal care. These seven people lived in four separate premises.

Some people used Makaton signs and symbols as they were unable to verbally communicate. Not all the staff had the skills, knowledge or competence in Makaton to effectively communicate with people. This had led to people who used Makaton to develop other ways of communication with staff.

Families and staff had mixed views on how approachable local managers were.

People received support from staff with other skills and knowledge to meet their needs, including how to support people with their nutrition and hydration needs. Staff had supervision and appraisal, however not all staff felt fully supported by their managers. People were supported to access other healthcare provision when needed.

Staff understood how to provide care to people in line with the Mental Capacity Act 2005 (MCA). Any restrictions on people had been taken in line with the MCA and took a least restrictive approach to ensure people's safety.

People received safe care. Staff had been trained and were knowledgeable about what actions to take to safeguard people from abuse. Any risks to people's health or risks in their homes were identified and assessed for what actions to take to reduce risks. Staff recruitment and deployment was managed safely. Procedures were followed by staff managing and administering medicines to ensure people received their medicines safely.

People were cared for by staff who were friendly and caring and who had built up positive relationships with people. People had their independence promoted and their privacy and dignity respected. People were supported to make choices and their views were reflected in their care plans. People were supported to enjoy a range of interests and hobbies in their communities.

The service responded to any issues raised and a procedure was in place to record and investigate formal complaints.

Care was responsive and personalised as it was focussed on meeting the needs of each individual person.

Care was regularly reviewed and evaluated to ensure it remained responsive. People and families had the opportunity to contribute to reviews of their relatives care.

There was a registered manager at the service at the time of our inspection. 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.

Systems and processes to check on the quality and safety of services and reduce risks to people were in place. Developments were in progress for staff to have improved access to IT. The service had also been developed with reference to person centred models of care and work.

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 care that was safe and risks were identified and assessed. Staff followed guidelines to ensure medicines were managed safely. Recruitment processes ensured staff employed were suitable to work with people using the service. Sufficient staff were deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff could effectively communicate with people who used Makaton. Staff had the other skills and knowledge for their role and staff received supervision and appraisal. People's care was in line with the Mental Capacity Act. People's needs in relation to their health and nutrition had been met.

Is the service caring?

Good

The service was caring.

People felt staff were caring and friendly. The principles of dignity, respect and independence were understood by staff. People were involved in what care and support they required and their known views and preferences were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care, responsive to their needs and were involved in planning and reviewing what care they needed. Issues raised with the service were responded to and a procedure was in place to manage and investigate formal complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was in place and was viewed as approachable. However, not all families experienced local managers as approachable and not all staff felt supported by their managers. Processes were effective in checking that the care provided met with standards of quality and safety. Person centred approaches underpinned approaches to people's care and staff appraisals.

United Response - Derwent DCA

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included one inspector.

Before the inspection we looked at all of the key information we held about the service. This included notifications. Notifications are changes, events or incidents that providers must tell us about. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service. We also contacted the local authority commissioning team, and Healthwatch Derbyshire, who are an independent organisation representing people using health and social care services.

People had limited verbal communication and were unable to tell us in any detail about the service they received. We therefore spoke with six relatives to get their views on the care given to their family members and two social care professional who was involved with the service. We also spoke with the registered manager, a service manager, one team manager and six support workers.

We looked at three people's care plans. We reviewed other records relating to the care people received and how the service was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records.

Good

Is the service safe?

Our findings

Family members told us risks were identified and any actions to reduce risks were taken. For example, one family member told us staff followed the advice given by a dietician to reduce the risks of choking. They told us this meant staff knew not to give their relative certain foods. Records showed risk assessments were in place to reduce risks to people. These included actions on how to reduce the risk of falls and prevent risks from scalding when using equipment in the kitchen.

Other risks from people who expressed behaviours that challenged were identified and assessed. Staff also told us any incidents of behaviour that challenged were discussed in team meetings. One staff member told us, "Every team meeting we look at how we can make things not trigger for the person." Staff told us they completed incident forms and we saw these were reviewed by managers and feedback given to staff if changes were needed. We discussed with the registered manager and service manager some recent changes to one person's care plan for managing their behaviour. They told us additional training had been arranged for staff as they had identified some inconsistencies in the approaches currently used. In addition, they told us a recent team meeting had discussed some immediate changes made to managing the person's behaviour in order to help reduce the known behaviour triggers for this person. We also saw staff reported any accidents or incidents and these were reviewed by the manager. The manager had recorded any actions taken to reduce any further risks. The registered person's had taken steps to reduce risks to people.

Families we spoke to told us where staff managed and administered any medicines to their relatives, this was done safely and recorded. One family member told us their relative took different types of medicine at different times. Although different staff administered them, they felt there was a system in place to make sure their relative received the right medicine at the right time. Staff we spoke with told us, and records confirmed, they had been trained in medicines management and administration. We also saw competency tests were in place to ensure staff were competent to manage and administer medicines. Staff told us they completed medicines administration record (MAR) charts when a person had taken their medicines. We reviewed some MAR charts as part of our inspection, and found these had been completed as expected. Processes were in place to ensure people were supported to receive their medicines safely.

Families we spoke with felt their relatives were cared for safely. One family member told us, "It's definitely safe; all lovely staff." Staff told us, and records confirmed, they had been trained in safeguarding people from abuse and preventable harm. Staff told us this training helped them to identify potential signs that could indicate a person was experiencing some form of abuse. For example, staff told us any unexplained bruising would be reported and investigated. In addition, staff told us how regular, twice daily finance checks helped to keep people's money safe. Staff told us they would report any concerns over people's safety to their manager. In addition, records showed safeguarding referrals had been made to the local authority when needed. This meant the provider had taken steps to protect people's safety while they used the service.

The registered person's had checked to ensure staff employed were suitable to work with people cared for

by the service. Staff recruitment files showed checks on people's suitability to work at the service had been completed. This included references from previous employers, checks to confirm people's identity and checks on people's previous work history. Information had also been obtained from the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These checks helped the registered person's employ people suitable to work at the service. The provider had taken steps to protect people from the risks associated with abuse.

In this inspection, we looked at four different premises staffed by Derwent DCA. Family members told us there were enough staff. One person told us, "Staff are always there." Another person told us, "The core group of staff seem to be there." However some told us staffing arrangements would sometimes change due to staff not being available to work. They told us they were not sure how these staff absences were covered. Both families and staff told us the turnover of staff in some parts of the service had been high. The registered manager told us some recent vacancies had now been filled and previous vacancies had been covered by staff on overtime, or through a staffing agency. Where agency staff had been used, the registered manager told us, the same member of staff would be used to try and ensure consistent care.

Some staff we spoke with felt some people required more staffing than they received funding for. The registered manager told us they provided staff to meet people's needs as identified in their individual funding arrangements. The registered manager had identified where one person's needs had changed; they arranged a review with external professionals which resulted in an increase of staff hours for that person. Staff were deployed in sufficient numbers to meet people's identified needs and staffing arrangements were kept under review by the registered manager.

Requires Improvement

Is the service effective?

Our findings

Some families we spoke with felt staff needed more competence in their use of Makaton to offer effective care to their relatives who were non-verbal communicators. Makaton is a language program using signs and symbols to help people to communicate. However, other families told us staff did communicate effectively with their relatives by use of signs and symbols. One person's care plan had documented the signs a person made and what they meant. This helped to ensure staff had a consistent understanding of this person's communication method.

However, when we spoke with staff we found not all people were supported consistently with their communication. For example, one staff member who thought a person should receive full Makaton support was not aware of the most recent guidance from speech and language therapists to use a reduced amount of Makaton with this person. Another staff member told us they had worked out their own signs and symbols to use with a person who could already use Makaton. They told us they needed more training in Makaton to use it effectively. We were concerned people who used Makaton had to develop different ways of communicating with different staff members because not all staff were competent in Makaton. The registered manager told us all staff had received a basic level of training in Makaton however not all staff were confident and further training was in the process of being arranged. They also told us a Makaton book was available at people's homes to support staff in their communication. Staff we spoke with were aware of the Makaton book however told us it was not used consistently. Communication with some people was not always effective as not all staff knew the latest communication guidelines to use with people. People's known communication methods were not always supported consistently.

The Mental Capacity Act 2005 (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.

We checked whether the service was working within the principles of the MCA. The service was not providing support, at the time of our inspection, to anyone where an application had been made to the Court of Protection. However the registered manager had recognised a Court of Protection Order may be required for some people because of the restrictions placed on their freedom in order to ensure their safety. We saw the registered manager had documented a discussion with the local authority where this was the case. Restrictions were documented in people's care plans and had been based on a 'least restrictive' approach. This ensured people were safe without unnecessary restrictions on their freedom.

We reviewed the care plans for people who lacked the mental capacity to make specific decisions relating to their care and treatment. Care plans identified how people could be helped to understand any information about their choices and decisions, for example by the use of verbal communication or pictures. Any best interest meetings held were recorded and included contributions from other relevant people known to the

person, for example, family or staff. Staff we spoke with understood how the MCA applied to people. Care was provided to people in line with the principles of the MCA.

Staff received other training to help them care for people. One family member told us, "[Staff] support [my relative]; they're really good." Staff told us their induction period included introductions to people as well as several weeks shadowing more experienced members of staff before working on their own. Staff we spoke with and records confirmed, they received regular training relevant to the needs of the people they supported. One staff member told us, "The training is very useful." They went on to tell us the training on people's health conditions, such as epilepsy, dysphagia, managing behaviours that challenge and first aid had been, "Really relevant." Staff had other relevant skills and knowledge to meet the needs of the people they supported.

Staff we spoke with worked across all four different premises and had different managers. One staff member told us, "My manager is great; they help me anyway they can." However, some staff told us they did not feel supported. This was because some mangers had been difficult to contact or the responses they gave had not been helpful. Other staff told us they had been able to contact their managers or use the on call system if they needed any support. Most, but not all staff we spoke with, felt supported in their role.

We saw records of supervision with staff were regular and offered staff support and development in their roles. In addition, managers had observed staff, for example, when staff had supported a person on an outing, and had provided feedback on what they had done well and what areas they could improve. The registered manager had introduced a new appraisal system, based on person centred practices, with the aim of engaging staff more in the process.

People who received care with their meals had sufficient to eat and drink. One family member told us, "The Sunday roast always smells lovely when we go." Families also commented on how staff involved their relatives to make choices over their meals and helped them to prepare meals when the person wanted to do so. One family member told us their relative was helped to make suggestions for meal choices and helped choose items when out shopping. They told us, "Food wise, they have a varied diet and try and get involved in cooking." Staff we spoke with were aware of people's dietary needs and people's known food preferences. Care plans were in place where risk assessments identified any nutritional and hydration risks. The service understood how to support people with their nutritional and fluid intakes.

People were supported to maintain good health and had access to other healthcare services as required. For example, one family member told us their relatives visited the optician and dentist. When people had other health conditions people saw the relevant health professional. One family member told us, "[Staff] always take [my relative] to the specialist." Care plans showed a range of other health professionals were involved in people's care. For example, psychologists, speech and language therapists, Doctors and district nurses. People received relevant support with their healthcare needs.

Good

Is the service caring?

Our findings

Families told us staff were caring. One family member told us, "All the staff love [my relative] to bits." Another family member said, "[Staff] give lovely care; they are very friendly," and added, "They have a great laugh; it's like a family." A third family member told us, "It's a very caring service; they really do care for [my relative]." People had positive relationships with the staff that cared for them.

Families felt their relative's independence was supported. For example, one family member told us, "[My relative] gets themselves into the shower; they've learnt new skills and have more independence." Another family member told us staff had started to support their relative, "To pay for [shopping] themselves." They told us they thought this had helped them to become more independent with managing their own money. People were supported to develop their independence with everyday activities.

Care plans promoted people's independence, for example, one person's care plan stated they wanted to have as much control of their finances as possible and this included a weekly visit to the bank to collect their money. In addition, care plans stated the person used a money counter so they could be involved in the daily checks on the balance of their money. Most staff we spoke with felt care plans accurately reflected people's levels of independence, however one staff member felt one person's levels of independence had been over estimated in their care plan. We discussed this person's care plan with the registered manager and service manager who told us this person had varying levels of independence and staff would make a judgement on what assistance was required based on the persons needs at that time.

One family member told us they had raised an issue with staff around promoting their relative's dignity and this had now been resolved. Other families we spoke with told us they felt staff promoted their relative's dignity. All of the staff we spoke with told us they were mindful of respecting people's privacy and promoting their dignity. Staff told us they would do this by ensuring any curtains were closed and doors were closed if the bathroom was in use. Care plans identified what privacy and dignity issues were important to people. For example, one person's care plan stated, "My own bedroom is important to me; with a lockable door where my personal items are kept safe and protected." People received support from staff who supported the principles of dignity, privacy and respect in their day to day work.

Family members all told us staff tried to involve people in their care, and some staff were more confident than others at using non-verbal communication methods. However they told us, "[Staff] involve [my relative] with everything," and added, "Staff are quite good at listening to [my relative]." Another family member told us their relative was supported to express a preference for what they liked and disliked and told us staff would try different things to build up an understanding of what their relative's preferences were.

People were involved in planning their care. One person's care plan stated, "This profile has been written with me and the contents of this have been communicated to me verbally." It also stated the person's family member and staff had helped put the care plan together. Families we spoke with told us they were invited to discuss their relative's care. One family member told us, "Any decisions; I'm involved all the time." Another family member told us, "[Staff] want my opinion on things." People and when appropriate their families, had

involvement in care planning.

Good

Is the service responsive?

Our findings

Staff told us how people would communicate they were unhappy about an aspect of their care. They told us people who were verbal communicators would tell staff if they were unhappy, and would also involve their family members. Staff told us they observed people who were non-verbal communicators to see if they showed any signs of unhappiness with the service they received. For example, staff told us one person showed specific gestures if they were unhappy. Staff told us they responded to these gestures and try something different and discuss any changes in review meetings and involved the person's family members. Information for people on how to make a complaint was available in an 'easier to read' format with pictures and symbols to aid people's understanding. No formal complaints had been made within the dates covered by this inspection. However policies and procedures were in place to investigate any complaint, should one be made.

Some families we spoke with told us they had talked with senior staff over issues they felt needed to be improved. For example, one family member told us they had to speak with staff and take in additional clothing to ensure their relative's dignity was maintained. They told us after their input this had been resolved. They also told us their feedback on what type of skin products suited their relative's skin type had also been listened to. Two other family members spoke positively about the response they received to any suggestions they made for improvements.

Staff told us, based on their understanding of one person's needs, they felt the person would enjoy a specific holistic therapy. They told us this was arranged for the person to try; they found it beneficial and it now formed part of the person's activities. Care plans showed staff looked for the reasons behind any changes in behaviour where people were non-verbal communicators. For example, records showed staff reviewed a person's care routines when they had a change of behaviour. They could not identify any triggers to the person's behaviour changes and so thought the person felt unwell. They arranged a GP appointment who was able to identify and treat a medical need and the person settled back to their usual self.

In addition staff told us 'learning logs' were recorded and then discussed at team meetings. We saw one learning log had recorded a new activity a person had tried. The person was a non-verbal communicator and staff had recorded what had gone well and how the person had expressed their enjoyment during the activity. Other learning logs evaluated where new activities had not worked and made suggestions for what to try next. People received responsive and personalised care and specific attention was given to their individual needs.

Family members we spoke with told us they were invited to reviews of their relative's care. Most family members told us their views were listened to and used to help plan personalised care for their relative. For example, one relative told us, "At review meetings I'm asked for any suggestions." Another family member told us, "[Staff] are very good at informing me; they communicate very well."

We also spoke with two social care professionals involved in reviews of people's care. They told us each person was supported to be present at review meetings, and to contribute their views. Where people lacked

the capacity to understand the purpose of a review meeting, they told us staff that knew them well, or their family members would help by contributing what they thought the person would think about their care. Social care professionals we spoke with told us they were impressed by staff members' knowledge of the people they cared for and found staff communicated very well. Although some families had experienced difficulties having their views acknowledged, reviews of people's care were arranged. People's views and experiences were sought and used to plan improvements to their care and the service.

Family members we spoke with told us their relatives received care to participate in activities they enjoyed. One family member told us, "[Staff] take my relative out to clubs, church, singing, swimming; it's all very sociable." Another family member told us, "The swimming sessions do [my relative's] limbs good; it makes them better." They went onto tell us the other varied interests and hobbies their relative was supported to do. They told us after an activity their relative was, "More contented." Two staff members told us some people were supported to an 'Equality and Diversity club.' They told us people enjoyed food, music and crafts associated with a different country each week. In addition, staff told us one person worked at a café. The staff member told us, "[Name of person] really benefits from that independence; I can tell they really like it." People were supported to fulfil their aspirations, and to follow their interests and hobbies.

Requires Improvement

Is the service well-led?

Our findings

United Response Derwent DCA is required to have a registered manager and a registered manager was in post. There is a responsibility for registered managers and providers to send statutory notifications to CQC when required. Notifications are changes, events or incidents that providers must tell us about. The registered manager had submitted notifications when required to do so. Families we spoke with told us they were confident in the registered manager. One family member told us, "The registered manager is approachable; they're great." The registered manager was accredited by a nationally recognised person centred organisation to run person centred thinking courses for staff supporting people's care. They had also developed the staff appraisal system based on person centred thinking with the aim of engaging staff more in the process. Person centred research had been used to inform the service's culture.

We spoke with other managers during our inspection. One manager told us, "I've got a really great staff team; they will not do something for someone just because it is quicker to do so." Managers we spoke with valued their staff teams and spoke highly of the care they provided.

However, families' feedback on how approachable local managers were was mixed. One family member told us, "[The manager] tries their best," whilst another family member told us, "The manager is approachable; but they can be overpowering when they are talking."

We also received mixed views from staff on the management style of their managers that worked across the four premises in this inspection. Some staff had positive experiences, for example, one told us, "My manager is great; they help me anyway they can." While other staff told us they did not feel supported . Whilst staff told us they had raised concerns when they felt this was appropriate, some staff were not confident the appropriate actions had always been taken by their managers. Not all staff knew who the registered manager was and that this was an additional person they could raise their concerns with. We were concerned some staff reported a lack of confidence in their managers and in addition, did not know the registered manager was an additional person they could raise their concerns with. We discussed this with the registered manager would told us they would make sure all staff knew about their role and how to contact them direct if they had experienced any concerns with their direct line manager.

During our inspection, we spoke with the registered manager and service manager to obtain additional information on certain issues staff or family members had made us aware of. Some of the issues fell outside of the time period covered by this inspection; however one of the current issues we discussed related to the cleanliness of two separate premises where people lived. We discussed this with the registered manager and service manager. They were aware an issue had been raised in one of the premises and had taken action to investigate this further. They agreed to also investigate the second premises and told us this had previously not been highlighted during regular quality assurance checks at the premises. We saw copies of audit documents used to spot check premises and these included a prompt to check for cleanliness. We also spoke with two social care professionals; one who had involvement at one of the premises we discussed. They reported no concerns over cleanliness of the premises whenever they had visited.

Although family members told us their concerns were responded to, one family member told us it had taken a long time and a final solution had still not been reached. Another family member told us improvements had been made after they raised their initial concerns; however they felt they were now deteriorating again. Families were able to raise concerns and discuss how these could be resolved with the service. However for some families solutions took a long time, or they felt improvements had not been consistently maintained.

We looked at the other systems and processes the provider used to check on the quality and safety of people's care. Staff told us managers checked medicines administration charts and support plans were up to date and reviewed accident and incident reports. Records showed these checks were completed. In addition, records showed audits also checked financial safeguards were in place and safety checks had been completed on any vehicles prior to use. Where analysis of incident forms had indicated changes were needed the registered manager and service manager confirmed these were in progress. In addition, we saw where audits had identified shortfalls, action had been taken. For example, stock checks on medicines had identified one medicine was out of date and this had been returned to the pharmacy for disposal. Systems and processes were used to check on the quality and safety of services and took action to identify and reduce risks to people.

Policies and procedures were available to support staff and these were kept under review to ensure they stayed relevant and up to date. Updates to policies and other useful information had been communicated to staff in a briefing. The registered manager told us of a recent development they were in the process of implementing. Laptop computers were being provided for staff so up to date policies and procedures would be more accessible. They also hoped people could become more involved in reviews of their care by using laptop computers and for staff to submit health and safety checks and incident report forms online. Resources were made available to develop the service.