Diverse Abilities Plus

Diverse Abilities Plus - Supported Living

Inspection report

Unit C
Acorn Business Park
Ling Road
Poole
Dorset
BH12 4NZ
Tel:01202 418266
Website: www.diverseabilitiesplus.org.uk

Date of inspection visit: 21, 22 July 2014
Date of publication: 24/12/2014

Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Summary of findings

The inspection was announced. We told the provider two days before our visit that we would be coming to ensure that the people we needed to talk to would be available.

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

Diverse Abilities Plus Limited provides a supported living service for people with a learning disability, autistic spectrum disorder, older people, physical disability and younger adults. The service was supporting 35 people in 17 supported living properties. This is where people receive personal care and support in their own properties, some of which are shared with other people.

Some of the people we visited had complex needs and were not able to tell us their experiences. We saw that those people and the other people we spoke with were happy and relaxed with staff.

Staff had made some decisions on behalf of people because they were not able to make these themselves. Some people did not have their mental capacity assessed, and decisions made in their best interests were not recorded as they should have been as directed by the Mental Capacity Act. This was an area for improvement.

There were safe systems in place to safely manage and administer medicines for most people. However, we found that one person did not receive one of their medicines as prescribed on two occasions. This was an area for improvement.

People received care and support in a personalised way. Staff knew people well and understood their needs and the way they communicated. We found that people received the health, personal and social care support they needed. However, we found there was no system for recording or monitoring one person's weight. This was important because the person was at risk because they had complex health and dietary needs. This was an area for improvement.

One person told us they felt safe and other people were relaxed with staff which may have indicated they were comfortable with staff. Four relatives we spoke with said people were safe. Staff knew how to recognise any signs of abuse and how they could report any allegations.

Any risks to people's safety were assessed and managed to minimise risks. We saw people were supported to take part and try new activities and experiences in their homes and in the community.

People, professionals and relatives gave positive feedback about staff employed by Diverse Abilities Plus but they raised concerns about the use of agency staff and the impact this had on the service people received. The registered manager had recruited more staff to reduce the agency use and had made sure regular agency staff were used where possible.

Equipment was maintained and serviced as needed. People told us equipment was repaired promptly.

Staff were caring and treated people with dignity and respect. People and staff had good relationships. People had access to the local community and had individual activities provided.

Staff received an induction, core training and some specialist training so they had the skills and knowledge to meet people's needs.

People and their relatives knew how to raise concerns or complaints. People and relatives were regularly consulted by the provider using surveys and meetings.

The culture within the service was personalised and open. There was a clear management structure and staff, relatives and people felt comfortable talking to the managers about any issues and were sure that any concerns would be addressed. There were systems in place to monitor the safety and quality of the service 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?

Requires Improvement

The service was not consistently safe. Decisions were not made in line with the Mental Capacity Act and some medicines were not always administered as prescribed.

Staff knew how to recognise and report any allegations of abuse.

We found staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

There were effective infection control systems in place and staff had access to protective equipment, such as gloves and aprons. People had access to equipment that was maintained and serviced.

Is the service effective?

Requires Improvement

The service was not consistently effective because one person, who was at risk of malnutrition, weight was not being monitored. However, people's assessments and care plans accurately described the care and support they needed.

The staff had effective training and support to carry out their roles. People, their relatives and professionals felt staff were skilled and knowledgeable in meeting their needs.

For most people their specialist diets and needs were catered for.

Is the service caring?

Good

The service was caring. The people and their relatives told us that staff were kind and caring.

People and or their relatives were involved in decisions about the support they received and their independence was respected and promoted.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive to people and their needs.

Staff understood people's complex ways of communicating and responded to their verbal and non-verbal communication and gestures.

People were supported to pursue activities and interests that were important to them.

People and their relatives knew how to complain or raise concerns at the home about the service.

Summary of findings

Information was shared effectively when people moved between services. For example, when people went into hospital.

Is the service well-led?

Good

The service was well-led. Observations and feedback from people, staff and relatives showed us the service had an improving, positive and open culture.

Feedback was regularly sought from people, staff and relatives. Actions were taken in response to any feedback received.

There were systems in place to monitor the safety and quality of the service. There was learning from accidents, incident and investigations into allegations of abuse.

Diverse Abilities Plus - Supported Living

Detailed findings

Background to this inspection

An inspector visited the service on 21 July 2014 and 22 July 2014. We visited four different supported living services run by the service. We spoke with and met seven people either in their own homes or at the service's office. We spoke with four care workers, two team leaders, a deputy manager, the registered manager and the provider's representative. We spoke with four relatives by telephone.

Some of the people we met had complex ways of communicating and were not able to tell us their experiences of the service. All of the people we visited had 24 hour personal care and support packages from Diverse Abilities Plus. We observed the way staff supported people in their homes.

We looked at four people's care and support records and records about how the service was managed. This included, four staffing recruitment records, audits, meeting minutes, maintenance records and quality assurance records.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at incidents that they had notified us about. We also contacted two commissioners and eight health and social care professionals who work with people using the service to obtain their views.

Following the inspection, the registered manager sent us information about policies and procedures, end of life care, survey results, staff training and the training plan.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

One person told us they were safe and they knew who they could talk to if they didn't feel safe. We observed that other people who did not communicate verbally were relaxed in the company of staff. They smiled, touched staff and gave staff eye contact; this may have indicated they felt comfortable with the staff supporting them. All four relatives told us they felt their family members were safe. One relative said: "Yes he's safe I don't worry about him at all".

All of the staff had been trained in the Mental Capacity Act 2005, and the six staff we spoke with had a basic understanding about this and making decisions that were in people's best interests. However, we found that this knowledge had not been consistently applied.

One person had a mental capacity assessment completed by a health and social care professional. A best interest decision was then made by all the health and social care professionals involved with the person. This related to a behaviour management plan for when the person chose not to get out of bed or refused personal care. However, we saw that two people had bed rails in use to minimise the risks of them falling out of bed but they did not have the capacity to make this decision themselves. There were not any mental capacity act assessments or best interest decisions in use for these bed rails. Two people also had listening monitors in place so that staff could hear when they had an epileptic seizure or to monitor their well-being at night. One person told us they knew why the monitor was in place. However, the other person was not able to verbally communicate and may not have had the capacity to agree to the monitor being in place.

The lack of mental capacity assessments and best interest decisions was an area for improvement.

Staff had been trained in the administration of medicines and records showed they had their competency assessed to make sure they were safe to administer medicines. Staff we spoke with were knowledgeable about each person's medicines and how and when to administer them.

We looked at the medicines plans, administration and monitoring systems in place for people. There was a written handover between each change of staff that checked whether each person's medicines had been administered and signed for. Where any errors or omissions were identified an error log was completed. The staff member responsible for the error was taken off medicines administration until they had been reassessed as competent by a manager or team leader.

Three of the four people had received their medicines as prescribed. However, on two occasions in the previous two months, one person's patch to reduce their saliva production had not been applied every 72 hours as prescribed. There was a delay of 24 hours before this patch was applied on both occasions. This meant the person would have experienced excess saliva production during that time. We discussed this with the person's team leader and care worker and they told us that the current way of checking medicines had not identified when this person's patch was due to be applied. This was because the frequency of when it was due changed as the patch sometimes fell off when the person had a bath.

These shortfalls meant that one person did not receive their medicines as prescribed. This was an area for improvement.

All of the staff had received training in safeguarding adults from abuse as part of their induction and ongoing training. All of the staff we spoke with knew the different types of the abuse and were confident about how they could report any allegations.

The registered manager had reported any allegations of abuse to both the local authority and CQC. They had cooperated fully with any safeguarding investigations. We saw they had taken action following any investigations to make sure that any learning was shared with staff.

We found people had effective risk assessments and plans in place for; their home environment, pressure areas, nutrition, medicines, falls, access to the community, behaviours which may challenge others and epilepsy management. There was a positive focus on risk taking so that people were able to try and experience new activities. One relative told us: "He has a blooming good life, he went to a festival this year, I'm happy they are positive about him taking risks."

The staffing levels for each person were based on their assessed needs and determined by their funding authority. All of the people we visited had one to one staffing and 24

Is the service safe?

hour care packages. The registered manager told us that if people's needs increased they would approach their funding authority for an increase in the amount of hours provided.

Two people, the registered manager, staff, professionals and relatives told us that most of the time people were supported by regular staff teams who knew their needs well. We received some feedback from professionals and relatives about their concerns about the ongoing use of agency staff. One relative told us: "There is a brilliant team at the moment; the only problem is when there are agency staff". This was also reflected in the family and friends survey completed by the service.

The registered manager told us that they had been recruiting to vacant posts that were currently being covered by agency staff. They said they used regular agency staff where possible so that people were supported by staff they knew. We saw from records that the agency staff use had reduced during the month prior to the inspection. We also looked at four weeks staff schedules for the four people whose care and support we were tracking. The schedules we looked at showed us people were supported by regular staff teams. Two of those teams included some regular agency staff.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people in their homes. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

We looked at the maintenance and service records for people's equipment in their homes and found that equipment had been serviced as required. One person's bathroom ceiling hoist was being repaired whilst we visited. The person told us: "There's a team of people who look after the house and they come round if there's problems, like today".

Two health and care professionals told us that staff were not always sure who was responsible for equipment such as beds and hoists. This had meant staff had incorrectly referred equipment repairs or requests to the wrong agency and this had delayed people having access to equipment. We spoke with the registered manager and staff whilst we were visiting people's homes. They told us and showed the recording systems in place for the servicing of equipment related to the delivery of personal care and who was responsible for the maintenance of equipment. The registered manager acknowledged that there was not a central record in relation to the ownership and maintenance of equipment and that it was reliant on staff knowledge in each supported living service. The registered manager told us they planned to implement a central record so they could monitor whether equipment was being serviced and repaired as required.

There was an infection control policy and procedures in place. Records showed and staff told us, they had been trained in infection control. Staff told us, and we saw in people's homes, that protective equipment such as gloves and aprons were available. Infection control and cleanliness was checked in each service as part of the quality reviews completed by managers every two months.

One person had a medical condition which required specific infection control measures to make sure the individual remained free from infections. The two staff who were supporting the person were able to explain in detail the procedures for managing this. What staff told us reflected what was written in the person's care plan.

Is the service effective?

Our findings

All four relatives we spoke with felt that staff had the skills and knowledge to meet people's needs. One relative said: "Staff are really well trained and are introduced to [the person] slowly, slowly which is really important to him".

People's nutritional needs were assessed, monitored and planned for. Each person had an 'eating and drinking' plan that detailed the person's likes, dislikes, types and consistency of food and drink and the type of equipment people needed. For example, one person's plan detailed they had their food in bite size pieces and used a spoon to eat with. The plan included the person did not like to drink hot drinks but that they did like to have a hot drink to dip their biscuit in. Staff we spoke with told us what was written in this person's plan and we saw their daily records included the food and drink the person had each day.

One person had been identified as being at risk of having poor nutrition. This was because the person had complex learning and physical disabilities and did not communicate verbally. We observed staff supporting the individual with a drink and it was the consistency described in their care plan. However, we identified that the person had not been weighed nor was any weight recorded in their care records so staff could monitor whether they had gained or lost any weight. This meant for this person staff potentially could not identify whether the person had lost weight. This was an area for improvement because there was no means of assessing and monitoring the person's weight.

Staff told us they had one to one support and annual development meetings and felt well supported by managers to fulfil their roles. We saw records of these meetings and annual development plans in staff files.

The registered manager showed us the induction programme and workbook for staff. This included the staff's roles and responsibilities, information about the provider and detailed information about the people they would be working with. In addition to this staff completed the Skills for Care Common Induction standards, which are nationally recognised induction standards. Staff we spoke with had a good understanding of their roles and a new member of staff told us the induction had prepared them for working at the service.

The provider sent us the training plan and staff training records. We saw that staff completed core training that included the provider's compulsory and specialist training. For example, infection control, moving and handling, epilepsy and emergency medication, safeguarding, person centred approaches and total communication.

People had access to specialist health care professionals, such as physiotherapists, community mental health nurses, dieticians, occupational therapists, speech and language therapists and specialist consultants. For example, one person had complex epilepsy and saw a neurological consultant at a local hospital on a regular basis. Another person had a complex health condition that required treatment and surgery at a specialist hospital. Staff had been trained by the consultant surgeon to manage the person's condition so they could remain in their own home. We saw from records and discussion with staff that the person's health and well-being had improved significantly since the surgery.

We spoke with relatives about the healthcare their family members received. One relative said; "Staff know [the person] so well now they know the signs of when he is unwell. I'm so confident now I don't even tag along to hospital appointments".

Each person had a health plan that was supported by pictures to make it easier for them to understand and included important information about them if they went into to hospital.

People's health needs were assessed and planned for to make sure they received the care they needed. One person was at risk of developing pressure sores. We saw from records, and from talking with staff, they were regularly repositioned throughout the day and night as detailed in their plan. They also had a specialist wheelchair and bed mattress to minimise the risk of pressure damage.

Another person needed to be positioned in a certain way in a specialist bed at night. Their care plan was supported by photographs so staff could see how to assemble the bed and safely position the person. The staff we spoke with said the photographic plans gave them clear easy to follow information.

A third person had epilepsy and there was an epilepsy care plan in place that included the use of required medicine. Staff described how the person presented whilst they were having an epileptic seizure and at what point they would administer the required medication.

Is the service caring?

Our findings

During our visits to people's homes we observed staff supporting them in their homes. People were respected by staff and treated with kindness and compassion. Staff showed affection for people and recognised and knew them as individuals. Staff were very positive about people, their strengths and abilities. They celebrated people's differences, for example, staff acknowledged that although people had disabilities they were able to achieve their own goals and try new experiences. There was an understanding from staff that any behaviours that may have challenged others were about the individual trying to communicate and this was not viewed in a negative way.

We saw that people who did not communicate verbally gave staff eye contact and were responsive to staff when staff spoke with them. We observed two of the people chatted, laughed and joked with staff. They told us they liked the staff, one person said: "[staff member] is nice I like them all". Another person said: "I always get the right support and care from staff". All four relatives we spoke with were positive about the quality of care people received and the kindness of staff. One relative said: "Life is very good for [my relative], he's a very lucky young man".

From observations and speaking with staff we found they knew people and understood their preferences. We found that people's care plans included how people made their preferences and choices in their everyday lives. We observed staff giving some people simple verbal choices and one person used eye-pointing to make a choice. Staff were able to tell us how each person made their preferences known. However, we noted that three people's care plans did not include their life histories. Staff who had worked with some people for a long time knew some of their personal histories and life stories but these were not consistently recorded. This meant that staff may not have all the information about people to be able to care for them in a personalised way and fully understand them.

We found staff respected people's privacy and dignity. For example, staff asked people's permission before letting us into people's homes and checked with them whether we could look at their records. Where people were not able to give their permission, staff sought the consent of their relatives.

We saw staff supported people discretely when they needed any personal care or support to eat and drink. One person had a specific plan in relation to supporting them with their personal care when they were presenting some challenges to staff. The member of staff described how they supported this person to maintain their dignity during these times. The staff member told us how they focused on positive behaviours and reassured the person. This reflected what was written in the person's care plan.

Diverse Abilities Plus had developed a 'person centred planning course' for relatives and representatives so they could better understand how people were being involved in planning and decision making.

People and or their representatives had been consulted about their end of life wishes. These were recorded and plans were in place where needed. The plans were supported by photographs and pictures and used language that was easy for people to understand.

The registered manager told us they had recently supported one person to make a decision about resuscitation whilst they were in hospital. They had supported the individual to fully understand the information and had challenged the decisions that had been made by the hospital. This was because the hospital had made a decision without consulting the person about their wishes. The person now had an Independent Mental Capacity Advocate (IMCA) appointed to make sure their views were considered. This is an independent person appointed to represent and support the person in relation to their 'best interests'.

Is the service responsive?

Our findings

During our visits to people's homes, all of our observations showed us that staff were responsive to people's needs. Staff responded to people's verbal and non-verbal gestures and communication.

We saw that people's care plans and records were supported by pictures and photographs to make it easier for people and staff to understand. For people who did not communicate verbally they had a DVD made about things that were important to them. These DVD's included important information about how the person communicated, how they ate, drank, how they were positioned in their wheelchairs, and how they liked to spend their time. A relative and staff member told us this was a really useful way for staff to get to know the individual. Relatives told us they were involved in care planning where the person was not able to make those decisions themselves. We saw people and or their relatives had signed their care plans to show they agreed with them.

All of the staff we met and spoke with understood people's complex ways of communicating. This reflected what was in people's communication plans or communication passports. These were documents that people kept with them to show other people how they communicated and what they liked and did not like. A health and social care professional told us that experienced staff who had worked with people for a long time could "read their body language and general communication expertly". Staff were able to explain how people let them know if they wanted anything. For example, a staff member explained that one person clapped their hands to show they were happy and tapped their head if they were anxious or unhappy. They also explained that the person would look at drinks and roll their tongue when they wanted a drink. All of this information about how the person communicated was also included their care plan, their 'expressions' book, which was a book that included photographs and explanations of what the person's expressions meant, and their DVD.

We saw from care records and speaking with people, staff and relatives that each person had the opportunity to be occupied both in their homes and in the community. People had access to activities that were important to them and had individual activity plans. For example, people had been to festivals, gone sailing, swimming and attended local singing groups.

People and relatives told us they had family and friends to visit them at their homes and they were supported to maintain important personal relationships. A relative told us staff made arrangements for them to regularly meet up with their family member; they said, "We usually meet up on a Sunday and walk the dogs. It's great now they have their own dog".

Two of the people we met worked on a voluntary basis for Diverse Abilities Plus. One person worked one day a week in the office and the other person was a 'care ambassador' for Diverse Abilities Plus. This is a nationally recognised scheme to raise the profile of training and careers in the care sector. They were also involved in the recruitment of the staff that supported them and were a member of a local advocacy group. Other people who used the service were also involved in delivering person centered planning and communication training to new staff.

People's cultural and religious needs were considered. For example, one person told us they were supported to attend their place of worship every Sunday. They said: "I've been going to the same Church since I was three, it's a really nice community, it's important I go every week".

We looked at four people's assessments and care plans and saw that they had been reviewed on a monthly basis. Overall, apart from one person, action had been taken to amend care plans if people's needs had changed. Staff told us they had a hand over every day where they discussed people's needs and if anything had changed for any individuals. There were monthly house meetings with the people who lived in each supported living service. There were minutes and records available and staff said managers and team leaders made sure they read these. They said that these systems made sure they were all kept up to date with people's needs and things that were happening in each service.

People we spoke with told us they could raise concerns with any of the staff and they would sort their concerns out. One person said: "If I'm worried I talk to (team leader) and she always sorts it out". Staff we spoke with also had a good understanding of how people communicated when they were upset and how to support people to make a complaint. The four relatives we spoke with told us they knew how to make a complaint. One relative said: "If there have been any issues I've let them know and it's been dealt with, it's always been sorted out".

Is the service responsive?

There was a written and pictorial complaints procedure and each person's communication plan included details as to how they would let staff know if they were unhappy or worried. We looked at the one complaint received by the service over the last twelve months. We found this had been investigated and responded to minimise the risk of reoccurrence.

We spoke with relatives and looked at records about the way Diverse Abilities Plus supported people when they moved between services. For example, when they went into hospital. We saw that each person had a hospital passport document. This included important information about the person such as how they communicated, their physical and personal care needs, any moving and handling information and the equipment they used, and what they liked, what they did not like and what upset or frightened them. Relatives told us staff supported people to attend hospital appointments. The registered manager told us staff stayed with people during hospital stays. This was to make sure the hospital staff were supported to understand people's needs.

Is the service well-led?

Our findings

Observations and feedback from people, staff, relatives and professionals showed us the service had an improving, positive and open culture. This was because the registered manager had introduced more consultation with people, relatives and staff. This included surveys, new IT systems, meetings and newsletters.

A newsletters was used to share information with people, staff and health and social care professionals. The registered manager had also set up a new monthly family and friends meeting to share ideas and information. This was in response to comments in the family and friends survey.

The registered manager told us that they and the deputy managers undertook quality reviews in the supported living services every two months. We saw the records of these reviews for the people we visited. They covered areas such as; activities, medication, cleanliness, handover records, accident records and the care and support provided to people. From these quality reviews an action plan was produced for the team leader to complete and follow up. A team leader we spoke with confirmed that these reviews took place and that managers followed up on the actions to make sure any shortfalls were addressed.

Financial audits were completed six monthly for each person to ensure their finances were managed safely. These included action plans that were then followed up by a different staff member. The registered manager told us they planned to increase this to three monthly.

We looked at the systems in place for monitoring and learning from incidents, accidents and safeguarding. We saw these were reviewed on a monthly basis and any actions and learning form incidents was shared with staff at team leader and team meetings and or at one to one support meetings.

The registered manager told us that in response to concerns being raised about team leaders and managers having to cover the 'on call' system on their days off, a new 'on call' team had been recruited. They were due to start their induction in August 2014.

The registered manager and team leaders told us there were now monthly team leader meetings at the office and they were being provided with portable IT equipment to make communication easier. We were told they were having objectives set to make them more accountable and develop a more consistent approach across the services.

Health and social care professionals and commissioners told us there were some differences in the way each supported living service operated and this was directly linked to the stability and consistency of the staff teams. Those services with stable staff teams knew the people, their communication and needs well and were able to follow occupational therapy and physiotherapy programmes consistently. However, they told us that in other supported living services, where there was a high use of agency staff, people's therapy programmes were not always followed.

The registered manager had taken action to address the concerns identified with agency staff and had started a monthly meeting with the staffing agencies. We saw the minutes of these meetings had identified that only regular agency staff would be used and agency staff were to attend the organisation's training and specialist training to work with individual people. Diverse Abilities Plus's staff were able to raise any concerns about the practices of agency staff by completing an incident record. We saw these records and that any issues or concerns were followed up with the staffing agency by the registered manager.

There were written compliments from professionals, relatives and people's representatives. The registered manager said these were shared at team meetings so staff received the positive feedback.

All of the staff we spoke with knew how to whistleblow and raise concerns. They were confident that any issues they raised would be addressed. We saw in staff records an example of where a staff member had whistleblown and what action had been taken in response.

Diverse Abilities Plus had a programme of 'thank you' awards that recognised staff good practice.

We found, from staff records and from speaking with staff, they understood their roles and responsibilities. All staff were issued with a staff handbook, code of conduct and a clear description of their responsibilities and who they were accountable to. We saw from staff records and from

Is the service well-led?

discussion with the registered manager that any issues with a staff members' performance was followed up in annual appraisals, one to one support meetings or through the disciplinary process.