Southside Partnership

Southside Partnership Domiciliary Care Agency

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?	Outstanding

Overall summary

This inspection took place on 14 and 22 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. At our previous inspection on 8 November 2013 we found the provider was meeting regulations in relation to the outcomes we inspected.

Southside Partnership Domiciliary Care Agency provides personal care for people in supported living accommodation. They have a number of supported living schemes across Bromley and Lambeth. However, not all of the people receive personal care. Our inspection was focused on the people that received personal care.

There was a registered manager at the service. A registered manager is a person who has registered with

Summary of findings

the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service told us that staff looked after them and treated them well. We found staff were familiar with safeguarding procedures and had been given safeguarding training.

Risk assessments were carried out which helped to ensure that people were able to take part in daily activities in a safe manner. Risk assessments included a risk management plan which identified the level of risk and contained an in-depth management plan. Staff explained how they encouraged positive risk taking with the necessary measures put in place to ensure people were able to have some independence.

People received their medicines safely and received ongoing health care support. Guidelines were in place to ensure people received their medicines correctly and staff completed medicine records when they administered medicines. People had health action plans and hospital passports in place which had been reviewed recently. There was evidence that specialist professional support was sought for more complex needs such as speech and language therapists and physiotherapists.

Staff members went through robust recruitment procedures. They were required to spend some time with people using the service which was closely observed by a manager, who assessed how they interacted with people. There was a comprehensive induction based on the care certificate and a six month probation for new staff. The providers training manager was responsible developing the Care Certificate induction modules for managers to support staff with and training of new and existing staff. Staff received ongoing support and told us they were satisfied with the training opportunities they were given.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and its application. Staff were aware of the importance of asking people for consent and the need to have formal best interests meetings in relation to decisions where people did not have the capacity to consent. The provider had taken into consideration where people had some restrictions placed on them and had submitted applications to the authorising body in respect of these people.

Care records were person centred and developed with the help of an in-house intensive support team. They helped to ensure behaviour support plans were in place and specialist advice was available to support staff in areas such as intensive interaction and positive behaviour support.

Quality assurance was central to monitoring the way service was run. A newly recruited head of quality had put in place a number of ways in which quality was monitored and measured across the organisation. A quality framework had been developed, bringing together a range of quality outcomes from external organisations and implementing them within the service and seeing what areas needed to be improved. Feedback was sought from people in a manner that was accessible to them.

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. Staff had received safeguarding training and were aware of what steps to take if they suspected people were at risk of harm.

Risk management plans were in place that helped to ensure people were kept safe.

People received their medicines safely.

There were enough staff available to meet people's needs and robust recruitment checks were carried out on new staff.

Is the service effective?

Good

The service was effective. Staff told us they felt supported and were valued within the organisation. They received regular training and supervision.

The provider was meeting its requirements in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

People had their healthcare and nutritional needs met by the provider.

Is the service caring?

Good

The service was caring. People's homes were personalised to their liking and they told us that staff had a caring attitude.

Care plans were person centred.

Staff were careful of respecting people's privacy and dignity when carrying out personal care.

Is the service responsive?

Good

The service was responsive. People had access to activities of their choice and were given support by staff to take part in these.

People were given information on how to raise concerns in an accessible format. People were able to raise concerns in key worker meetings.

Is the service well-led?

Outstanding

The service was well-led. Staff told us they felt supported and valued.

Specialist internal teams were available to provide expertise in areas such as positive behaviour support, person centred planning and intensive interaction.

Quality assurance audits were thorough and the service continuously looked at ways of improving the service based on feedback or incidents.

Southside Partnership Domiciliary Care Agency

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 14 and 22 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team comprised two adult social care inspectors. One inspector visited two supported living schemes on 22 October 2015 to speak to people in their homes.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with two people using the service, we also observed staff supporting another person who was not able to communicate verbally. We spoke with five staff, the registered manager, a service manager and the head of quality. We also observed interaction between staff and people using the service. We looked at three care records, four staff files and other records related to the management of the service including training records, audits and quality assurance records. After the inspection, we contacted health and social care professionals to ask their views about the service.

Good

Is the service safe?

Our findings

People using the service told us that the staff were "nice" and one person said, "They look after me." Staff had received safeguarding training and were able to identify the different types of abuse and what steps they would take if they suspected people were at risk of harm. One staff member said, "If I have any concerns, I have to whistle blow." There were policies and procedures in place in relation to safeguarding and contact numbers of the safeguarding team were available in the schemes that we visited. There had been no safeguarding concerns at the service within the past year.

We checked financial records at one of the schemes we visited. Staff clearly recorded when people using the service took money out for their day to day needs and receipts were retained. The service manager said that financial audits within schemes were a three stage check, the first being a physical count of the money held and whether it corresponded to the amount recorded, checking of the receipts and finally a reconciliation of the previous months financial checks. These checks were carried out monthly.

Risk assessments were individual for people and staff were able to explain why these were in place and how they were used to help keep people safe. They were reviewed every six months to ensure they contained up to date information. Each person had a 'person centred risk management plan' based on specific circumstances, these identified the level of risk and contained an in-depth management plan to mitigate the risk to ensure people were safe to take part in activities. For example, moving and handling risk assessments for people were specific to each situation such as transferring from a bed to wheelchair, and from a wheelchair into the bath. A risk log was also maintained which was a record of any activities that contained some risk to people but did not require a specific management plan because existing guidelines/ practices were sufficient to ensure the activity was safe to carry out.

Staff explained how they used risk management plans to help ensure people were kept safe. They gave one example where a person who had previously been able to make hot drinks independently now needed staff support. The risk assessment for this person had been updated and measures put in place to ensure they were still able to have some independence by assisting staff to make hot drinks. One staff said, "We encourage positive risk taking so we don't deprive [people]."

Behaviour support plans were in place to manage behaviour that challenged the service. These were comprehensive in scope and identified potential behaviours, the triggers and plans to prevent them from occurring. They gave clear guidelines on what steps staff could take, for example use short sentences, use objects and gestures, and avoid negative statements. They also gave information about strategies that worked and did not work and a response plan if people started to display behaviour that challenged.

We found that there were robust recruitment checks in place to help safeguard people. Staff provided evidence of their identity such as their driving licence, passport and evidence of their address. Two written references from previous employers were requested and criminal record checks were sought. Potential staff went through a two stage interview process, the second of which was an observation exercise spending time with people using the service. An observation chart was completed by a manager and looked at how they interacted with people. There was a six month probation for new staff. We saw some completed probation reviews and found they were comprehensive in scope and looked at staff's communication, leadership skills, teamwork, areas for further training and a development plan.

We found that staffing levels at the schemes we visited were sufficient to meet people's needs. In one of the schemes in which two people stayed in a three bedroom flat, there were two care workers available during the day to support them with personal care and any activities they did during the day and one person in the evening. In the second scheme, one staff was always on duty providing 24 hour support and they slept in at night. People were supported by familiar staff teams with bank staff available to provide cover in case of staff absence, which was confirmed by members of the support staff team.

People received their medicines in a safe manner and their medicines were stored and disposed of appropriately and staff kept accurate records. Each person had a medicines profile which was written in an easy read format. These gave details of the medicines taken, the dose and what they were used for. This had been reviewed within the past

Good

Is the service safe?

year. Medicines files contained PRN guidelines that had been signed by a GP. This is an abbreviation of 'Pro Re Nata' and is commonly used on medicine administration charts to indicate that a medicine should only be given 'as needed'. Weekly medicines checks took place.

Good

Is the service effective?

Our findings

Staff told us they enjoyed working at the service and felt supported. Some of the comments included, "Its lovely", "I feel supported", "I've had training in moving and handling and dealing with choking incidences which has helped me to support [person]", "I enjoy working here" and "We get loads of training and we have opportunities to keep updating them."

The providers training manager was responsible developing the Care Certificate induction modules for managers to support staff with and training of new and existing staff. The registered manager told us that they had implemented the new Care Certificate and adapted it to their own service to provide a comprehensive induction programme for staff.

The provider had developed three modules and workbooks taken from the 15 standards of the Care Certificate for new starters to obtain this qualification. This had been implemented for all new staff from June 2015. The induction programme lasted for three months and new staff worked through the training modules and workbooks, overseen by their line manager who signed them off at point of completion. The modules were 'Me and Certitude', 'Me and the people I support', and 'Me and working safely'. This showed staff were provided with the knowledge and skills in order to understand the values of their organisation and safely meet the needs of the people they supported. The qualification also gave them a foundation to progress to more advanced national qualifications in health and social care.

The training that was delivered to staff as part of the induction included health and safety, safeguarding, infection control and communication. We saw an example of a completed workbook which covered the importance of feedback, the vision and values of the provider, key policies and team procedures.

Ongoing training was delivered via a mixture of e-learning and classroom based learning. Staff were able to book onto available courses via the company intranet. The registered manager showed us a training matrix on which records relating to each supported living scheme were kept. She was able to identify from this spreadsheet when training had been completed, and how many months were left for the training to expire. Staff were provided with training in a range of areas that were relevant to supporting people with learning disabilities, including person centred planning, positive risk assessment, epilepsy, choking and resuscitation. In addition, a number of other areas were covered including first aid, medicines,, food hygiene, equality and diversity, moving and handling, fire safety and health and safety.

One to one supervision sessions took place every six weeks and an annual review system was in place. Annual reviews looked at what had worked well, objectives and leadership. One staff member said, "We get regular one to one, we have a brilliant manager. Very supportive."

We observed staff asking for people's consent, for example asking them what they wanted to eat for lunch and whether they wanted to speak with us. Staff also said they made sure people made decisions for themselves wherever possible but were supported when doing so. One staff member said, "[person] likes to choose what necklace she wants to wear and we offer people a choice in terms of when they want to get up" and "It's their home, we respect their wishes."

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the registered manager. She demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. She told us that due to people's profound learning disabilities, they all needed constant supervision. We saw evidence that the provider had completed formal checklists for people recording whether they had capacity, were free to leave and were under constant supervision in line with the Act. Based on this checklist, they had submitted applications to the local authority to deprive people of their liberty under formal procedures and were awaiting the results of their applications.

Each person had a 'decision making agreement' in which their ability to understand decisions and information related to financial and medical matters were recorded. We

Good

Is the service effective?

saw that these were individual for each person and took into consideration people's understanding of different situations. For example, in relation to financial matters it was found that one person was able to manage money below £10.00 and so was able to spend this money as they wished. Best interests meetings were held in consultation with family members and support workers for any money that needed to be spent above this amount. Staff were aware of importance of the MCA and its application in relation to people they supported. One staff member told us, "We wouldn't force them or restrict them, I would try and explain to him" and "We have to contact social services if we need to restrict people, and follow their guidelines."

People's dietary needs were being met. They told us, "I had cheerios for breakfast", "I went out for lunch, I had a burger." The kitchen was clean and stocked with fresh fruit and good quality food. Where dietary recommendations were in place, staff were familiar with them. One staff member said, "[person] has diabetes but we manage his/her diet, we offer him/her lots of fruit."

Another person had dysphagia, this is a medical condition which causes difficulty in swallowing and therefore required a pureed diet. We saw that they had a comprehensive speech and language therapist review in April 2015. This review involved observing the person a number of times to understand their eating habits. It gave detailed guidelines in terms of ideas for meals, food, drink, positioning, seating, assistance/equipment and environment. Staff were provided with appropriate equipment to support this person.

We found that people's healthcare needs were being met. Evidence was seen of regular check-ups with health professionals such as GP's, podiatrists and opticians. People had a person centred 'My OK Health Check' which was written in an easy read format and provided information related to people's checks in relation to their health check such as vision, hearing, skin and circulation. People had hospital passports and health action plans in place that had been reviewed within the past year. The aim of a hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

Health action plans recorded support needed in relation to a person's health needs and the level of support needed. We also saw evidence that where specialist input was required, staff acted to ensure this was met. For example, one person who enjoyed swimming was referred to physiotherapist who carried out and developed a 'management of a physical disability a 24-7 assessment tool.'

Good

Is the service caring?

Our findings

People had positive things to say about the caring attitude of staff that supported them. People told us, “I like it here”, “Staff are nice”, “[Member of staff] looks after me”, “She helped me to make my bed.”

People’s bedrooms were personalised to their liking. One flat had a number of sensory stimulation items in it and was personalised with pictures of holidays and days out. The bathroom had been adapted into a wet room to make it easier for showering. Other bedrooms had been decorated to a style of people’s choosing. Our observations were that staff were providing support in a caring manner and people looked relaxed in their homes. One person was watching a sensory DVD, other people went out for lunch or were spending time in their rooms.

Staff were familiar with people’s preferred ways of communicating, either verbally or non-verbally. People had a communication profile in place, giving guidelines to staff on the best way of communicating with people. Some people used objects of reference to help them communicate and staff showed these to us during our inspection. These had been developed by specialists within the organisations and external speech and language therapists. It gave staff guidance on things such as the best way for people to get their message across, what they found difficult, what they understood and what staff could do to help them. Staff said, “I can tell by [person’s] body language what they want, [person] is not shy of expressing himself.”

Staff were aware of the importance of respecting people’s privacy and dignity when supporting them with personal care. “We have two bathrooms. When we support [person using service] the door is closed. He/she prefers to change in his/her room so we make sure he/she is covered.”

Each person had a support guideline in place so staff had access to information about people’s preferences in relation to their night time routine, challenging behaviour and personal care. Care records contained people’s specific needs covering aspects of their daily living that were important to them. Care records were written in plain English and were person centred.

There was evidence that people were provided with support from an Independent Mental Capacity Advocate (IMCA) when they needed support in making decisions related to their care and welfare, for example when moving placements. We saw evidence in team meeting minutes that staff had requested an advocate for a person using the service who was unable to express their own choices. One staff member told us that two people had advocates and that an advocate had been used for one person when they wanted to go on holiday.

The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about issues such as serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Good

Is the service responsive?

Our findings

We found that the service was responsive to people's changing needs. People had an assigned link worker who took a lead on supporting them and managing their needs.

We looked at a sample of care plans which were held electronically within the office and also in people's homes. We reviewed some person centred plans and saw that they had been developed with the person in mind, rather than being task orientated. Information included important family members, friends and others in people's lives, what a typical good and bad day looked like, important to and for people, their hopes and dreams and how staff could support them to maintain their independence.

The provider had a person-centred development manager who facilitated the development of person centred care plans and also took a lead on training staff within the organisation. Care plans were reviewed by the manager, on a yearly basis or more often if circumstances changed.

Specific support plans were in place to enable staff to meet people's needs. For example, an epilepsy support plan gave information about the frequency, patterns, triggers and the description of recovery for a person who had epilepsy. Working guidelines were also in place for medicines, finances and other tasks such as preparing meals. Behaviour support plans identified the behaviour, prevention plans, effective strategies for supporting people, response plans and monitoring of behaviours. Outcomes and goals monitoring were looked at during monthly link worker meetings. Some of the entries that staff had entered for goal monitoring said ongoing or no change, although we saw that people were being supported to achieve their goals. This indicated that records were not kept up to date in relation to people's goals and achievements.

Staff completed daily verbal handover between shifts so they were kept informed of any issues relating to medicines, health and safety, money, safeguarding, complaints and accidents. Daily logs were also completed; these recorded what had worked well and not well, what activities had taken place and what people had eaten.

We saw that people led independent lives and were supported to take part in activities of their choosing. One person had a set plan for the week which included going out twice a day and their week consisted of visits to the day centre, sensory room and swimming. They also had a mobility car to help them get around. Staff made comments such as, "[person] goes to exercise class every Wednesday. They go out to lunch together" and "We have been supporting [person] to take the bus which he/she enjoys."

Formal complaints went directly to the chief executive who assigned the complaints to a manager to investigate. There had been no formal complaints from people using the service in the last year, and only one from a health care professional which had been resolved satisfactorily after an investigation. We saw evidence that where people had complained, the provider had responded to them using an accessible format to support their understanding.

Outstanding ☆

Is the service well-led?

Our findings

Staff praised the management of the service and told us they felt able to express their views openly. One staff member said, "They are approachable, if you have any issues you can always call on them." Another said, "I love working here" and "The values are what guides me."

The provider had an intensive support team who had been in post for over a year and provided support to the service in areas in which people could have their needs met. The team consisted of a range of professionals including a qualified learning disability nurse, qualified Makaton trainer and specialist in intensive interaction, person centred development manager, behaviour support practitioner and a positive behaviour support manager who was a qualified Board Certified Behaviour Analyst (BCBA). This helped to ensure that people received highly personalised care and support that met their needs.

A number of areas were checked and handed over at each shift including medicines management, finance, the cleaning rota, health and safety checklist, water temperature, fridge freezer checks, and first aid. Each supported living scheme had a manager who carried out monthly checks and reported any findings to service managers. Service managers completed their own audits which looked at whether records relating to people using the service, such as action plans, support plans and hospital passports were up to date. Other records such as health and safety files, medicines, food hygiene were also audited. Observation visits based on a care mapping tool were also carried out on an ad hoc basic but generally once a year. This is a tool that enables staff to observe and record care from the viewpoint of people using the service. We saw that actions were assigned for people to follow up if any issues were picked up.

External auditors carried out other audits for example health and safety, and fire risk assessments. We saw a fire maintenance report and records showed monthly fire door checks and quarterly fire drills.

The provider had effective systems in place for disseminating information across the organisation about good practice and how to monitor it.. A good practice intranet link and an email was sent out to staff every week highlighting any good industry practices. A system called 'Certitrack' was for high level monitoring of the various supported living schemes. This was used to monitor individual outcomes for people and care records monitoring.

The head of quality carried out high level monitoring of audits carried out by service managers to help ensure any identified actions were followed up. The head of quality had also recently developed a 'Certitude quality framework' to look at the things they did, how well it was done and how it could be improved. The quality framework brought together a range of quality outcomes from organisations such as the Care Quality Commission (CQC), Quality Assurance Framework (QAF), The National Institute for Health and Care Excellence (NICE), and Think Local Act Personal (TLAP) into three main quality outcomes to measure their own quality against.

QAF allows community and voluntary organisations to look at their strengths and weaknesses and continuously improve their quality. TLAP is a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support. The three quality outcomes for Certitude were based on engagement, inclusiveness, and robust governance and commitment to continuous improvement. We were given a practical implementation of how this worked through a review carried out by the health and safety committee after some medicine errors, to minimise these from occurring in the future. The first quality framework gave guidance on new legislation around food allergy, and good Do Not Attempt Resuscitation practice. This showed the in-depth way the provider benchmarked the quality of care for people using the service, in accordance with reputable national guidance

The provider was a member of a number of community networks which demonstrated their commitment to providing a service that met the needs of people. These included a national charity called In Control and the Voluntary Organisations Disability Group .

Annual satisfaction surveys were sent out to people at the end of September, the results of which had not been fully analysed by the time of our inspection. A range of accessible methods were used to gather people's views including giving people an easy read version, carrying out face to face interviews and using an online version of the survey.

Outstanding ☆

Is the service well-led?

A staff survey was also completed which had a good response rate of 69% overall and 49% across staff working within the learning disabilities team. We looked at the results of this and saw that staff gave positive feedback in relation to leadership such as their trust confidence in the leadership team, their ability to act on results. Staff were also satisfied with the training and coaching/mentoring opportunities available. They were less satisfied with the induction but we saw that the provider had made changes to the induction, which were not fully reflected in the feedback of staff.