

SeeAbility

Seeability Surrey Support Service

Inspection report

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Ratings

Overall rating for this service

Good ●

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?

Good ●

Summary of findings

Overall summary

Seeability is a domiciliary care agency (DCA) and supported living service which provides support to people at two houses. The DCA provides personal care to one person who lives in their own home. Some people had profound physical and learning disabilities with sight loss. Whilst other people living in another service had sight loss, learning disability and some physical disabilities. Supported living and the DCA provide a waking night and sleep in where appropriate for each home.

People had varied communication needs and abilities. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's health needs and behaviour presented challenges and was responded to with one to one support from staff.

This inspection took place on 28 January 2016 and was announced. 48 hours' notice of the inspection was given because the needed to be sure that the registered manager was available as they manage a number of services in different locations.

The service was run by a registered manager, who was present on the day of the inspection visit. '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 and associated Regulations about how the service is run. Each house had a deputy manager that was responsible for the day to day management. Whilst the registered manager provided support to all the services.

Some people's human rights may have been affected as the requirements of the Mental Capacity Act 2005 was not always followed. Where people were assessed to lack capacity to make some decisions, people did not always have a mental capacity assessment or best interest meeting. Staff were heard to ask people for their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

Staff had written information about risks to people and how to manage these. We found the registered manager considered additional risks to people in relation to community activities and changes had been reflected in people's support plans.

The service was creative in the way it involved and worked with people, respected their diverse needs, and challenges discrimination. It seeks ways to continually improve and puts changes into practice and sustains them.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures

to follow should they have any concerns. One staff member said they would report any concerns to the registered manager. They knew of types of abuse and where to find contact numbers for the local safeguarding team if they needed to raise concerns.

Care was provided to people by a sufficient number of staff who were appropriately trained. Staff were seen to support people to keep them safe. People did not have to wait to be assisted.

People who may harm themselves or displayed behaviour that challenged others had shown a reduction of incidents since being at the home and the number of staff on duty were adequate for their individual needs.

Processes were in place in relation to the correct storage of medicine. All of the medicines were administered and disposed of in a safe way. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

At one of the houses people were provided with homemade, freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night. At the other house people were supported to be independent in their choice of food, and supported to shop and cook when they needed to. We were told by the registered manager that people could go out for meals if they wished.

People were treated with kindness, compassion and respect. Staff took time to speak with the people who they supported. We observed positive interactions and it was evident people enjoyed talking to staff. People were able to see their friends and families as they wanted and there were no restrictions on when people could visit the home.

People were at the heart of the service; and took part in a wide range of community activities on a daily basis; for example trips to the shops, and attending college. The choice of activities was specific and innovative to each person and had been identified through the assessment process and the regular house meetings held.

People had an individual support plans, detailing the support they needed and how they wanted this to be provided. We read in the support plans that staff ensured people had access to healthcare professionals when they needed. People's care had been planned and this was regularly reviewed with their or their relative's involvement. A relative told us "We have meetings with the staff regarding their care and we are asked about our opinions."

The registered manager and deputy managers told us how they were involved in the day to day running of the home. It was clear from our observation that the managers knew people very well and that people looked at them as a person to trust. Staff felt valued under the leadership of the registered manager. The home seeks ways to continually improve and puts changes into practice and sustains them. The had a robust system of auditing processes in place to regularly assess and monitor the quality of the service or manage risks to people in carrying out the regulated activity. The registered manager had assessed incidents and accidents, staff recruitment practices, care and support documentation, medicines and decided if any actions were required to make sure improvements to practice were being made. The service notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders.

Complaint procedures were up to date and people and relatives told us they knew how to make a complaint. Complaints had been responded to in line with the service's complaints policy. Confidential and procedural documents were stored safely and updated in a timely manner.

Staff were aware of the home's contingency plan, if events occurred that stopped the service running. They explained actions that they would take in any event to keep people safe. People's views were obtained by holding regular meetings and by communicating on a daily basis.

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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

Medicines were managed safely, and people were supported to take their medicines themselves. Medicines were stored and administered safely.

The provider ensured there were enough staff on duty to meet the needs of people individually.

Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Written plans were in place to manage risks to people. There were processes for recording accidents and incidents.

Is the service effective?

Requires Improvement 

The service was not always effective.

The requirements of the Mental Capacity Act were not always followed.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were offered a choice of food that met their likes and preferences.

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required if they had concerns about their care.

Is the service caring?

Good ●

The service was caring.

People told us they were well cared for. We observed caring staff that treated people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff took time to speak with people and to engage positively with them.

People were treated with respect and their independence, privacy and dignity were promoted. People and their families were included in making decisions about their care.

Is the service responsive?

Good ●

The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Support plans and risk assessments were reviewed and updated when needs changed.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

Staff supported people to access the community which reduced the risk of people being socially isolated.

People felt there were regular opportunities to give feedback about the service.

Is the service well-led?

Good ●

The service was well led.

There was an open and positive culture which focused on people. The manager operated an 'open door' policy, welcoming and acting on people's and staff's suggestions for improvement.

The registered manager had a robust system in place to monitor the quality of the service provided and as a result continual improvements had been made.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

Seeability Surrey Support Service

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 28 January 2016 and was conducted by two inspectors. We gave the provider 48 hours' notice of the inspection as we needed to be sure that someone would be available on the day we visited the office.

Before the inspection, we reviewed all the information we held about the provider. We contacted the local authority commissioning, quality assurance and safeguarding team to ask them for their views on the service and if they had any concerns. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the provider is required to tell us about by law.

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 used a number of different methods to help us understand the experiences of people who used the service. We spoke with three people, six members of staff, the two deputy managers, the registered manager, the regional service manager and six relatives.

We reviewed a variety of documents which included seven people's support plans, medicine records, four weeks of duty rotas, maintenance records, all health and safety records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to

send us some additional information following our visit, which they did.

This was the first inspection of this service since the registered office was located at this address in June 2013.

Is the service safe?

Our findings

People told us they felt safe and did not have any concerns. One person said "I love it here, the staff really look after me." One relative told us "(Family member) has no road sense; staff make sure that X is safe when they are out."

Staff had a good understanding of what constituted abuse and the correct procedures to follow should abuse be identified. For example, one member of staff explained the different types of abuse and what the local authority safeguard protocols were. They said, "I would report anything or phone the local authority myself." The registered manager showed us the safeguarding policy which was in place and staff had signed to show they had read and understood their responsibilities.

Staff had individualised and personalised guidance so they could provide support to people when they needed it to reduce the risk of harm to themselves or others. Support plans contained risk assessments in relation to people who required one to one supervision, as well as individual risks such as walking to the shops and attending hydrotherapy. Where needed there were risk assessments in place for people which detailed risks and how to manage them for eating and drinking, choking and the use of bed rails.

Staff told us they had signed the risk assessments and confirmed they had read and understood the risks to each person. They were able to describe individual risks to people and how to address these to keep people safe.

There was a transparent and open culture that encouraged creative thinking in relation to people's safety. People's choices on how they lived their lives was the first priority and the registered manager and staff ensured that people had access to achieve this. Assessments of the risks to people's safety in relation to life choices they had made had been developed while ensuring that people remained as independent as possible and had a meaningful and fulfilling life. For example, one person requires support to bath and full support to wash, due to the person's high needs. However the risk assessment states that the person is able to hold the shower head on their own and should be encouraged to do this.

There were safe procedures in place for the administration and storage of prescribed medicines. The registered manager said that they encouraged people to be as independent as possible with their medicines. We looked at medication administration records (MAR) and confirmed this had happened. Staff and people administered the medicine collaboratively as directed and this showed us that people had received their medicines as prescribed and that staff managed medicines safely and appropriately. One person said "My medicines are stored in my room. And staff always come to me, to remind me when to take them."

Some people required staff support to enable safe administration of their medicines. There were clear guidelines in place for staff so they knew how the person needed or liked to have their medicines administered. For people that were prescribed as required medicine (prn), such as some pain relief, there

were guidelines in place which detailed the signs people would display that may indicate when the person needs the medicine administered.

The registered manager told us that staffing levels were determined based on people's needs. Their dependency levels were assessed and staffing allocated according to their individual needs. For example, three people received one to one support and supervision. We saw on the day that people had their 1:1 support. The registered manager told us staffing levels were constantly reviewed to meet the changing needs of people, we were told that extra staff employed by the provider would be used if necessary. Staff and relatives told us they felt there were enough staff to meet people's needs.

Staff recruitment records contained information to show us the provider had taken the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

The registered manager had systems in place for continually reviewing incidents and accidents that happened within the home and had identified any necessary action that needed to be taken.

The registered manager told us the home had an emergency plan in place should events stop the running of the service. People had personal emergency evacuation plans in place (PEEP) which guide staff on how to safely support a person if there is an emergency. Staff confirmed to us what they were to do in an emergency.

Is the service effective?

Our findings

People's human rights could have been affected because the requirements of the Mental Capacity Act were not always followed. 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.

For some people who lacked capacity to make decisions regarding their care, mental capacity assessments and best interest decisions had not always been completed. For example, for those people who lacked capacity regarding their consent to care, use of moving and handling equipment and attending activities.

People's next of kin often consented to the care on the persons behalf. Next of kin does not give people the legal right to make choices about people's care. This meant that decisions made on the person's behalf may not have always been made in the person's best interest. We discussed this with the registered manager and they told us that they would complete these as soon as possible. The regional service manager told us they were reviewing the documentation and supplied us with information about this after the inspection. Since the inspection the registered manager has sent in evidence of completed mental capacity assessments and best interest meetings for people.

Some mental capacity assessments had been completed for example some people had best interest meetings regarding signing their tenancy agreement.

The registered manager and staff had an understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff were seen to ask for peoples consent before giving care throughout the inspection.

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. Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to seek authorisation and to ensure that people's liberty was being deprived in the least restrictive way possible.

One person said "I always tell the staff what I want." Staff ensured people's needs and preferences regarding their care and support were met. Staff were knowledgeable about the people they supported.

People were encouraged and supported to be involved in the planning and preparation of their meals. The registered manager told us that people had been asked if they wanted community meals and six people in one home stated they only wanted a group meal once a week. The registered manager said that this happened. All other days people were supported to shop and cook for the food they wanted to eat on a daily basis.

For people who required more support with their meal times, staff prepared the meals. People who were unable to communicate verbally were supported to make their choice by using picture cards, body language or a switch. People had adapted cutlery, plates and cups if they were needed to help them to eat and drink independently. We observed one person being supported by staff in the kitchen to make themselves a drink. One person who was unable to communicate verbally was able to choose the drink they wanted and what cup they wanted to drink it from.

Some people were PEG (percutaneous endoscopic gastrostomy) feed; these are used when people have significant swallowing problems receive their food directly into their stomachs. Staff administered the food safely to people.

People's weight was monitored on a monthly basis and each person had a nutritional profile which included the person's food allergies, likes, dislikes and particular dietary needs. Some people were at risk of choking. Both homes had plans in place to minimise these risks and all staff we spoke to were aware of the people that required food to be cut up into small pieces or mashed for them to eat safely.

Staff told us they felt they had the knowledge and skills to care and support people. Staff received training which included how to support people in a safe and dignified manner that may be at risk of causing harm themselves or others. Staff had access to a range of other training which included MCA, DoLS and manual handling, interactive communication, sight loss and managing epilepsy. For those staff that were supporting people with using a PEG had training from a health professional. Staff were up to date with their training and were assessed for competency by the registered manager in certain topics such as administration of medicines. They were observed undertaking care practices to ensure that the dignity and respect of people was upheld. This meant staff developed essential skills to provide the appropriate support to people in a positive way.

Management supported staff to review the appropriate induction and training in their personal and professional development needs. The induction consisted of the recommended Skills for Care induction (Skills for Care is the employer-led workforce development body for adult social care in England. By working with employers and sharing best practice). Induction for staff included shadowing other staff members for up to three weeks, to observe the care and support given to people. The deputy manager would observe the new starter give care to people and if competent sign them off. The registered manager and deputy managers held regular supervision sessions with staff which looked at their individual training and development needs.

People were supported to maintain their health and wellbeing. Support plans contained up to date guidance from visiting professionals and evidence that people had access to other health care professionals such as GP's, psychiatrist, speech and language therapist (SALT), health care specialists in epilepsy and chiropodists. People had specific care plans in place for their sight loss, which detailed the support required to maintain people's eye health. The services had a SALT available to them from within Seeability who could assist with communication advice and support with swallowing difficulties.

Is the service caring?

Our findings

One person said "the staff are really kind to me." Another person said "The staff support me in things I want to do." A letter of compliment from a member of the public said "I saw your staff giving a person their full attention; It was a joy to witness." One staff member said "I like working here as I am greeted daily by people's smiles."

Relatives told us that they were happy with the care and support that their relative received. One relative said "I am happy with the care and support (family member) has here." Another said "I am very satisfied with the support (family member) gets here." Another said "(Family member) has really good care here, we could not be happier. (Family member) is happy, we are happy."

We spent time in communal areas and observed staff interaction with people. We saw companionable, relaxed relationships were evident during the day. Staff were attentive, caring and supportive towards people. Staff engaged with people using humour, singing, touch and reading.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people are able to say how they felt about the caring approach of the staff. Staff knew they needed to spend time with people to be caring and have concern for their wellbeing. The conversations between staff and people were spontaneous and relaxed. Staff understood the different ways in which people communicated by using people's preferred communication method, for example makaton (makaton is a language programme using signs and symbols to help people communicate) and use of body language. One staff member said "(Persons name) can't verbally communicate, but I know them, by their reactions and body language. (Person's name) loves to chat and be interactive with me."

People looked relaxed and comfortable with the care provided and the support received from staff. One person was heard talking to staff throughout lunch, seeking advice and support. We heard staff reply cheerfully and with kindness to their requests.

People were well dressed and clean. For example, with appropriate clothes that fitted and tidy hair which demonstrated staff had taken time to assist people with their personal care needs. One person told us, "I always chose what I want to wear."

People were treated with dignity and privacy. Staff gave good examples of how they would provide dignity and privacy by closing bathroom doors and other examples. We observed staff maintain a person's dignity by wiping their mouth whilst they were eating and drinking. Staff did this subtly and gently.

We observed staff calling people by their preferred names and knocking on bedroom doors before entering. People at Ashted all had keys for their bedroom doors and key fobs so they could come and go freely. For people who could not verbally consent to staff and visitors going into their bedrooms, staff asked the person and waited for their response, for example a smile indicating a yes.

We observed staff members speaking with relatives professionally and with warmth. Staff asked the relative how they and the person was and told the relative what the person had planned for the day.

There were no restrictions on when people could visit their relatives. Relatives told us that they were free to visit at any time. One relative told us "I can pop in, even if (family member) is out and staff will make me a cup of tea."

People who had been assessed as requiring one to one support had this provided with consistency and the same member of staff was assigned to the person throughout the day which gave the person reassurance that their care would be delivered consistently. The registered manager and staff were knowledgeable about people and gave us examples of people's likes, dislikes and preferences.

Staff told us they reviewed peoples' support plans regularly. They said they would involve the person in reviewing their care and ask for input from relatives. Support plans had been signed by either people who used the service or their relative. Relatives told us that they were involved in people's care plans. One relative we spoke to said "We have meetings with the staff regarding (family member's) care and we are asked about our opinions."

Is the service responsive?

Our findings

One person said they had been supported to undertake activities that they were interested in. They told us "I've been to Barcelona on holiday and I choose it". Another person said that they went to computer classes. A staff member said "People are the back bone of the home, everything evolves around them."

Records we viewed and discussions with the registered manager demonstrated a full assessment of people's needs had been carried out before people had moved into the service. The deputy manager told us how people had a transition period into the service to ensure that people and staff could get to know each other prior to them moving in.

People's care and support was planned proactively and in partnership with them. Staff use innovative and individual ways of involving people so that they feel consulted, empowered, listened to and valued. Support plans comprised of various sections which recorded people's choices, needs and preferences in areas such as nutrition, healthcare and social activities. We saw each area had been reviewed at regular intervals. Staff said they used various different communication methods for this such as photos and PECS (picture exchange communication). People who were able to told us they had been involved in reviewing their plan of care. One staff member said "Your not doing things for people – You are supporting them to live their lives."

Relatives told us that they were involved in people's care planning and reviews. A relative told us "I am very involved in their care plan, they are reviewed yearly. (Family member) has a good keyworker and communicates very well with me."

There was a keyworker system in place, who sought the person's views and supported them when planning activities, holidays and opportunities to access the community. Two people showed us their support plans which they had been involved in planning.

People were supported to undertake social and educational activities of their choice which reduced the risk of people being socially isolated. People said about activities they had taken part in. One person told us "I go to work part time." Another person said they liked to go shopping and how they had enjoyed going to the theatre. On the day of our inspection people had gone out on a range of activities, one person was attending Scouts whilst others had gone to the hydrotherapy pool and horse riding. Other people were engaging in tasks in their home such as cleaning and sensory activities and others had been supported to day centres.

People were at the heart of the service. Staff spent time chatting with each person and responding to their need for companionship. People and their relatives had been asked about their personal histories and any interests or hobbies and efforts were made to support people to continue with these, for example one person had attended college they wanted to learn how to Skype. Another person was supported by staff to use a tablet to access interactive sensory games.

Staff ensured that people's preferences about their care were met. A relative told us "Staff knows (family

member) very well, if (family member) has an issue staff know what to look for." One staff member told us there was always a handover and the first thing they did was to read the communications book. They had written daily notes about people and would highlight any changes to the needs of the person to the registered manager so that the care plan could be reviewed for accuracy. People's health passports were regularly updated. A health passport is a useful way of documenting essential information about an individual's communication and support needs should they need to go into hospital.

The registered manager said people were encouraged to be independent. For example, clean their room, do their own washing, help prepare meals and drinks, attend college. Each person did their own personal shopping with staff. One staff member told us "I like to support (person's name) to be as independent as they can be, even if that means I support (person's name) to take a plate to the kitchen, or they can hold a cup on their own."

People were actively encouraged to give their views and raise concerns or complaints. The services saw concerns and complaints as part of driving improvement. People's feedback was valued and people felt that the responses to the matters they raised were dealt with in an open, transparent and honest way.

The registered manager showed us the complaints policy and explained how they would deal with a complaint if one arose. Most relatives told us that they openly discussed issues when needed with the management and told us that their concerns were dealt with effectively. Two relatives from one service told us that the management did not take on their concerns and complaints and felt that they were not listened too, as the same issues were being raised and were not being addressed. The registered manager told us they take complaints seriously, and they would ensure the outcome of the complaint was fed back to the person concerned and actions implemented if necessary. We looked at the services complaints and we found that complaints had been responded to in line with the services complaints procedure.

Is the service well-led?

Our findings

Staff said they felt supported by the management of the services. One person said about the deputy manager at one service "They help me do the things I want to do." We saw compliment letters from families, a comment from these was "We would like to thank you all for the attention and care you give our daughter."

There was clear management oversight provided to all the services. Whilst most relatives told us that they could speak to the registered manager and were happy with the arrangements, two other relatives told us that they felt that there was a lack of management in place.

There was an open and positive culture which focused on people. We observed members of staff approach the registered manager during our inspection and observed an open and supportive culture with a relaxed atmosphere. Staff felt they would be taken seriously by the registered manager if they wanted to raise concerns and the managers in place knew people well. We saw the registered manager and the deputies interacted appropriately with people and with kindness and care. Staff told us they had been supported through their employment and were guided and enabled to fulfil their roles and responsibilities in a safe and effective manner.

Staff told us they had staff meetings regularly and could always request extra meetings if they wanted to talk about anything. We saw minutes of staff meetings, items on the agenda included CQC and inspections, people's needs and training. They said they were kept up to date in between meetings by the registered manager and during handovers these meetings acted as group supervision. The staff showed us the communication books that were used regularly as a daily method of sustaining continuity of care.

The registered manager carried out a robust audit process to ensure the quality of the service and drive improvements in best practice. These included checks of support plans, all aspects of the environment, fire safety and personalisation. To enhance and update their knowledge and service delivery, the registered manager researched and reviewed varied publications and websites that specialised in providing guidance and advice to improve health and social care. Guidance and advice were followed in practice when they were appropriate to people's needs.

The registered manager and deputy managers had developed and sustained a positive culture in the service encouraging staff and people to raise issues of concern with them, which they have always acted upon. The registered manager gained daily feedback from people about their choice and preference. People had been supported to complete satisfaction surveys. A family member and professional's survey had recently been completed.

All the policies that we saw were appropriate for the type of service, reviewed annually, were up to date with legislation and fully accessible to staff. The staff knew where they could seek further guidance and how to put the procedures into practice when they provided care.

The registered manager had ensured consistently that the appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely throughout the home.

Relatives told us that they were involved in developing the services. In one service relatives told us that their opinions were sought when decorating the communal areas and they were involved in the planning of an extension of the property. Relatives also told us that they have been involved in staff recruitment, often sitting on the interview panel when interviewing for care staff.