Care Quality Commission

Affinity Trust

Affinity Trust - Domiciliary Care Agency - Shipley and Airedale

Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection was carried out on 26 & 27 July and 01 August 2016. The inspection was announced.

The last inspection was in December 2013 and at that time the provider was meeting all the regulations inspected.

Affinity Trust provides supported living and outreach services to adults with learning disabilities in Bradford, Keighley and Ilkley. At the time of the inspection the service was supporting 89 people, 83 of whom were receiving support with personal care. The supported living service was supporting 41 people in multi occupancy tenancies, typically occupied by three or four people, and the outreach service was supporting 42 people living in their own homes.

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

People who were supported by the service were protected from abuse and the risk of abuse. Staff were trained and knew how to recognise and report any concerns about people's safety and welfare. We observed people were at ease and comfortable with staff. We observed staff were kind and compassionate in their interactions with people.

People told us they were supported by the same staff most of the time. There were generally enough staff to provide people with the support they needed. The provider was in the process of recruiting more staff to provide cover for absence due to holidays, training or sickness and if possible eliminate the use agency staff.

All the required checks were done before new staff stared work and this helped to protect people from the risk of being supported by staff unsuitable to work with vulnerable adults. Newly appointed staff had a structured induction training programme to help them fulfil their roles and responsibilities. Following induction, staff received training on a variety of subjects to make sure they worked safely and had the skills and knowledge to meet people's individual support needs.

Risks to people's safety and well-being were identified and action was taken to remove, reduce or manage risks without compromising people's independence. People were supported to take their medicines safely.

People were asked for their consent and their views were respected. The service was working in accordance with the requirements and principles of the Mental Capacity Act 2005 and this helped to make sure people's rights were promoted and protected.

Staff treated people with respect, kindness and compassion. They knew people well and we found people were supported to be as independent as possible and make decisions about all aspects of their day to day lives.

We found the care and support provided to people was based on their individual needs and took account of their preferences. Where indicated people were supported to choose and cook their own meals and were encouraged to choose healthy options.

People had access to the full range of NHS services in order to meet their health care needs. When people had more complex health needs the service worked closely with community and hospital based health care professionals to make sure they received the right care and support

People were supported to access local amenities and take part in a wide range of leisure, education and work related activities which reflected their preferences and strengths.

People knew how to raise a concern or make a complaint, they were listened to and their concerns were acted on.

Staff told us they enjoyed working for Affinity Trust and said the registered manager and divisional director worked consistently to promote a 'person centred' approach.

Roles and responsibilities were clearly defined and the provider had a schedule of checks and audits which had to be carried out at specified regular intervals to monitor and assess the safety and quality of the services.

The provider promoted a culture of continuous improvement and the feedback we received from people who were supported by the service was unanimously positive.

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 knew how to recognise and report abuse and this helped to keep people safe.

There were enough staff to meet peoples support needs and new staff were not allowed to start work until all the required checks had been done.

People were supported to take their medicines safely. Risks to people's safety and welfare were identified and actions were taken to manage risks.

Is the service effective?

Good

The service was effective.

People's rights were protected because the service was working in accordance with Mental Capacity Act 2005.

People were supported by staff who were trained and competent to meet their needs.

People were supported and encouraged to have a healthy and varied diet.

People were supported to access the full range of NHS services in order to meet their health care needs.

Is the service caring?

Good

The service was caring.

People were treated with respect, kindness and compassion.

People were supported to be independent and make decisions about all aspects of their day to day lives.

Staff knew about people's support needs and how they preferred their care and support to be delivered.

Is the service responsive?

Good

The service was responsive.

People received care and support which was responsive to their individual needs.

People were supported to take part in a wide range of leisure, education and work related activities.

People knew how to raise a concern or make a complaint, they were listened to and their concerns were acted on

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which was open, transparent and positive and worked consistently to ensure the services provided were person centred, inclusive and empowering.

The provider had effective systems in place to monitor and assess the safety and quality of the services provided and promoted a culture of continuous improvement.

Care Quality Commission

Affinity Trust - Domiciliary Care Agency - Shipley and Airedale

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 26 and 27 July and 01 August 2016. The inspection was announced. The provider was given 24 hours' notice because the location provides a supported living and domiciliary care service for adults of all ages and we needed to be sure people would be available.

The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case domiciliary care services.

Before the inspection the expert by experience carried out telephone interviews with 14 people who were supported by the service, one person's relative and two support workers. During the inspection we visited the office and four of the supported living houses. In the course of the home visits we spoke with eight people who were supported by the service, four support workers and two supported living managers and looked at various records including people's support plans.

In the office we spoke with the registered manager and divisional director and looked at records which included people's support plans, staff files, training records, meeting notes, surveys and audits. In total we looked at 13 people's care records. Following the visits we spoke with another four support workers by telephone.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We asked the provider to complete 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. This document was completed and returned to us.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt very safe with their support workers. They said staff were kind and respectful and knew what they were doing. One person said, "I feel safe with them. They are my friends." Another person said, "I get to do lots of things and the staff help me a lot. They help me to sort out my money because I'm not very good at that." The staff we spoke with understood safeguarding and knew how to report concerns about people's safety and welfare. The provider had an electronic system for recording and monitoring incidents and accidents which rated the level of concern as red, amber or green (RAG). All safeguarding concerns were automatically rated as red which meant they had to be reviewed and signed off by a senior member of the management team. This helped to make sure safeguarding concerns were managed correctly and people were protected.

People who were supported by the service told us there was a lot of continuity of staff and said staff knew them well. One person said, "They look after me really well. They are nice staff and I am very safe here." Another person said, "They are all decent people and they are all very good. I am very safe and I like it here."

Affinity Trust provided two types of services, supported living and outreach and therefore used two different types of duty rotas. The supported living side of the service supported people in multi occupancy tenancies with a 24 hour staff presence in each house. These duty rotas were a three week rolling rota that was amended to include holidays, training and sickness. This meant staff knew what they would be working well in advance and could plan appropriately. It also meant that people living in the houses knew in advance what staff would be supporting them and this helped with their routines.

The divisional director told us the service rarely used agency staff as they were usually able to cover absences with their own permanent or bank staff. They said they were working toward a zero agency policy and were recruiting additional staff to ensure there was adequate cover for annual leave, training and other staff absence.

The second type of service offered by the provider was an outreach service where people were supported in their own homes or supported to access the community. This type of service was constantly changing to reflect the needs of the people they supported. This meant the rota was created on a weekly basis and often changed as people who used the service changed their minds about what they wanted to do. We also saw staff had to visit multiple people in a day with no arranged travel time in-between visits. This meant travel time would be absorbed by each visit or staff would be running late for further visits. We discussed this with the divisional director who agreed further improvements could be made.

People were referred from the local authority who agreed a number of support hours for each person. Affinity Trust ensured they supported people to the number of hours identified. Some people did not want or need to use their hours some weeks. These hours were 'banked' and recorded each week. This meant the people could 'bank' hours each week to enable a member of staff to then spend more time with them for a trip out or a holiday. These banked hours were reviewed and updated weekly by the support managers.

We looked to see if staff were recruited in a safe way. All seven staff recruitment files we looked at contained interview documentation, at least two positive references, ID checks and a Disclosure and Barring Service (DBS) reference number. DBS checks indicate if prospective staff have criminal convictions or cautions which would make them unsuitable to work with vulnerable adults. The records showed any gaps in employment were questioned at interview. We spoke with the divisional director who told us staff documents were recorded on their computer system as and when they were seen. Only once all the documents had been received could the registered manager sign off to say they were happy with a staff member's employment to start. This meant new staff was unable to start work until all their employment checks and interviews had been completed and signed off. Staff then received a one month shadow period with and experienced member of staff. This helped to protect people from the risk of receiving care and support from staff unsuitable to work in care.

The provider had policies and procedures in place to help make sure people's medicines were managed safely. Most of the people supported by the service managed their own medicines with varying degrees of support from staff. The level of support needed was recorded in people's individual support plans.

One person told us, "I can't take my own medication because I get confused so the staff sort it out for me and make sure I take the right things. They write everything down as well." Another person in one of the houses we visited told us staff explained what each tablet was for and supported them to make sure they took their medicines properly.

When people were prescribed medicines to be taken 'as required' we saw there were guidelines in place to help make sure the medicines were used consistently. In one case we saw a Medication Administration Record (MAR) had been hand written by staff and the information recorded did not correspond with the information on the label printed by the pharmacist. The hand written MAR had not been signed to show who had transcribed the information. This was discussed with the registered manager who assured us they would deal with it immediately.

In the houses we visited we saw there were information leaflets about all the medicines in use which included information about their uses and possible and side effects. We saw records were maintained of all medicines received and disposed of.

The registered manager told us all medication errors were recorded on the incident/accident system and were RAG rated depending on the level of impact. The rating determined the actions which needed to be taken. This was confirmed by the records. At the time of the inspection the organisation was carrying out an analysis of medication errors. This was being done across the country and co-ordinated by the provider's quality manager. When the analysis was completed the information would be used to identify areas where improvements could be made.

The care records showed risks to people's safety and welfare were identified and assessed and where appropriate actions was taken to eliminate, reduce or manage the risk. This included risks to people's physical well-being such as mobility, eating and drinking, choking and skin care and environmental risks, for example appliances. Risk assessments were also in place for specific areas risk such as epileptic seizures, behaviour which challenged or the risk of financial abuse.

One person who was supported by the service told us," The staff help me in the bath so that I'm safe. We're having a wall taken down next to the bannister and a new door put in which will make it easier for me."

There were clear emergency procedures in place and within the supported living services and each person

had a PEEP (Personal Emergency Evacuation Plan) which showed the level of support they would need in the event of an emergency. One person who was supported by the service told us, "If there is a fire, I have to get out of the house, we practice them a lot."

Staff had a good understanding of the responsibilities to promote and maintain people's safety and welfare. For example, one support worker said, "I know the people really well and am very familiar with the care plan and everyone's particular needs. I do look out for things in the house which might be a trip hazard or anything like that."

Within each of the three houses where people were supported, safety checks were carried out. These included checks on the fire safety systems, gas appliances, electrical appliances, water temperatures and the fabric of the buildings.

Accidents and incidents were monitored and analysed to look for trends and/or patterns. In addition to being monitored by the registered manager accidents and incidents were reviewed by the provider's senior management team.

Good

Is the service effective?

Our findings

A person who was supported by the service told us, "They [staff] all know what they're doing so I think they must be well trained." The relative of a person who was supported by the service told us, "My relative has experienced abuse previously in residential care and that has left them with depression and nightmares. I can't fault the support workers from Affinity Trust. They have done a lot of relevant training and know how to sooth them."

A member of staff told us, "I really like working for Affinity. They are a very supportive organisation and offer a lot of training."

New staff were required to undertake an induction training course that supported them in their roles. This was based on nationally recognised training standards for the care sectors.

Training was recorded and logged on the provider's computer system. The system flagged up when staff were due for training updates and if training was overdue. The support managers printed off a monthly report which identified those staff who were due for training or training updates. This enabled them to book the training courses in advance from a list of available courses. We looked at the mandatory training courses that all staff had to attend. We found the majority of staff had attended mandatory training and those who had not or were overdue for updates were booked onto a course.

Training was discussed in team meetings and supervision meetings with staff. Support managers had frequent contact with staff where they could inform them of any training needs. The support managers told us this worked well. We saw specialist courses available for those staff who worked with individuals with special needs. Staff confirmed this. For example, one support worker told us they supported a person who was deaf and said they had received training on BSL (British Sign Language) to help them communicate with the person.

We asked one of the support managers about how they supported staff. They told us when staff first started they had a monthly supervision to offer additional support at the beginning of their employment. This was followed by a three month probation review to check their progress and at the end of the six month probationary period they had another review to check their competence before their employment was confirmed.

After probation, staff had planned one to one supervisions every six to eight weeks. All staff were able to request supervision and we saw some general discussions had been recorded as informal supervisions. Supervision documents recoded staff welfare, concerns, training needs, the people supported, team working and the quality of the service. Supervisions were planned in advance and we saw staff had recorded supervision on a regular basis. Staff had an annual appraisal which looked at what was working well and setting goals for the coming year. A colour coded rating was applied to the goals from the previous appraisal so it was easy to see what was working well and what had not worked so well.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection (COP). We found the service was working within the principles of the MCA. The registered manager told us all people who used the service were assumed to have capacity initially. For those people who gave reason to potentially not have sufficient capacity to make an informed decision, capacity assessments were completed. These people had restrictions to their liberty in place, which led to referrals to the COP. The registered manager told us they had referred 14 people who currently used the service to the COP.

The divisional director told us staff had received training on the MCA and Deprivation of Liberty Safeguards. In addition, information about the support people needed with decision making was included in their support plans. This helped to make sure people were supported to make their own decisions. Where necessary people had the option of using advocacy services. We saw evidence advocates had been used in the past to support people with medical decisions.

Some people who were supported by the service needed support with eating a healthy and balanced diet. Staff told us they encouraged a balanced diet but ultimately it was people's own choice. People who required additional support with their diet had a support plan to reflect the help they required. We saw plans indicated some people required full support with cooking food and other people could make cold dishes themselves or with supervision. For example, in one person's support plan about preparing meals we saw there was a section titled 'what I can do for myself' and a section headed 'what I need support with'. The first section showed the person could peel and chop food, turn on the hob and oven, put things away and empty the dishwasher. The second section showed they needed support with straining food, boiling water, following recipes and working out cooking times. We saw the person was working toward a goal of cooking two dishes independently.

People's support plans also included information about their likes and dislike and any allergies they may have. We saw one person's plan indicated they could not have grapefruit as it would not support their medicines. Some people who used the service needed a specific type of diet, for example a soft food diet. Such details were captured as part of their support plan and staff had a good knowledge of the level of support they required, but also the importance of still making food look appetising.

Where appropriate people's weights were monitored and support staff worked with other health care professionals to make sure people's dietary needs were met.

We found people were supported to access the full range of NHS services. People's records included 'Health Action Plans' which were designed to support people with learning disabilities to be healthy and safe. In the records of one person who had complex health care needs we saw the support workers were working closely with several members of the multi-disciplinary team to ensure they received the right care and support. This included the GP, district nurses, a dietician, dentist, physiotherapist, occupational therapist and chiropodist.

Good

Is the service caring?

Our findings

All the people we spoke with told us the support workers were kind and compassionate. They said staff were respectful and polite and observed their rights and dignity.

One person said, "I'm very happy. I tell them what I need and they ask me as well. They are very cheerful and nice. I like (named support worker) very much." Another person said, "We have three permanent staff and they are all really nice." Other comments included, "It's nice to have our staff. They are good people." "Staff were very good." "I have lived here a while but I really like it here."

During the home visits we observed staff were kind and compassionate in their interactions with people. We observed staff respected people's dignity and privacy, for example in one of the supported living houses we saw a member of staff took the person into their bedroom to support them with their medication.

The staff we spoke with knew about people's needs and preferences and were able to tell us how people preferred their support to be provided. We found staff were committed to providing people with the best possible support. One member of staff said, "We try to go the extra mile. For example, one person's relative is very ill and we try to make things easier for her as well as the service user."

People who were supported by the service told us they were involved in decisions about their care and support and we saw evidence of this in the care records. People living in the supported living houses were also involved in making decisions about how the service was delivered. This was done by means of house meetings. For example, one person said, "We've had house meetings where we can talk about everything, We all get on well."

People's relatives also told us the service supported them to be involved in decisions about care and support and about how the service was delivered. One relative told us, "Because our relative has had really bad experiences in the past we asked Affinity if we could sit in on the interviews when they were appointing staff to care for our relative and this was readily agreed to. They have given us a lot of support.'

The registered manager told us when there was a vacancy in a house the existing tenants were consulted before anyone new moved in. Prospective tenants were invited to visit the house a number of different times and usually had an overnight stay before any decision was made about moving in. This was confirmed by staff working in the supported living services. The registered manager told us existing tenants had a 'veto' and if for whatever reason they did not feel the prospective tenant would fit in they would not be offered a place.

People supported by the service were also given the opportunity to be involved in how the service operated. For example, when Affinity Trust wanted to develop a charter they invited people to attend a series of art based workshops to help develop and design the charter. They charter remains in use and has four headlines – 'Respect, Listen, Support, Involve."

We found the service supported people to be as independent as possible. We saw people's support plans included goals to help them develop or learn independent living skills. People supported by the service confirmed this, one person said, "I'm very happy. I do gardening and charity work and athletics for disabled people. I decide for myself what I want to do." Another person said, "I volunteer at a café on Sundays and another one on Mondays. I do art and photography. I'm able to say what I want to do and I like to get out and about."

We found people's confidentiality was respected. Records were kept secure and we observed staff were careful how they spoke about people when there were others present.

The registered manager told us the service had in recent years supported people at the end of their lives. This had made it possible for people to die at home in familiar surrounding with family and a consistent team of staff. They told us on these occasions the service had worked closely with community health care professionals such as GPs, district nurses, palliative care and MacMillan nurses to ensure the wishes of the person and their families were respected. They told us they had an 'end of life plan' which they supported people to complete when they were ready to think about this aspect of their care and support.

Good

Is the service responsive?

Our findings

People we spoke with told us they were able to make their own decisions and said their preferences were taken into consideration. One person said, "I do lots of things and I like shopping but sometimes I don't feel like it and they (the staff) don't mind. They do ask if I'm alright and sometimes I change my mind and then we go." Another person said, "I go shopping at Morrison's and (named staff member) goes with me. They're taking me to Scarborough to see the cricket and I'm going on a trip to London." A third person said, "I do lots of things, go to see my family, horse riding, I love horse riding."

The feedback we received from people supported by the service and our observations showed people were supported to live as part of their local communities and access local facilities. We found people were supported in a wide range of work and leisure activities. The provider told us they supported a number of people to take domestic or foreign holidays and this was confirmed by people we spoke with and the records.

The registered manager told us they supported people to maintain relationships with family and friends in a variety of ways. For example, by supporting people to buy them birthday cards and/or presents. In another example we saw some people lived in supported living accommodation during the week and went to family for the weekends.

We looked at the care records of 13 people who were supported by the service. Support plans were stored in people's own homes and a duplicated version stored on the services computer system. We saw a difference is the level of detail included in care records depending if a person was using the outreach service or a supported living setting. We recognise that people who were supported by the outreach service would not have required the same level of detail as those in supported living due to less support needs. However, we still found care records lacked specific detail when describing the support tasks required by staff. For example one person's support plan said they required help with eating, but it did not describe what help was required. The same person's support plan indicated they needed help with having a device changed, but it did not indicate that the district nurses came in to complete this task.

The care records completed for those people who lived in the supported living service were very detailed and specific in their descriptions. We found a high level of detail including which arm to remove from a top first, when supporting someone to get undressed. One of the support workers we spoke with told us the care/support plans were very detailed. They said the people who were supported were very involved and added, "It is very person centred."

The provider told us where indicated people had a 'communication profile' which detailed how they wished to communicate and any assistance they required with this to enhance their abilities to make choices. We saw evidence of this in the records we looked at. We observed one support worker communicating with a person who had no verbal communication. We saw the support worker understood how to interpret the person's non-verbal communication and used their knowledge of the person's likes and dislikes to help them establish the person's wishes.

The provider told us the support plans were outcome focussed and included goals for each area where people were supported. All the individual goals were set out in one summary document and this was also used to record people's progress toward achieving their goals. We saw evidence of this in the care records we looked at. We saw in some cases photographs were used to illustrate people's goals.

The care records contained a section on how each person was involved in their care and support planning. We saw evidence some people had signed their care and support files to indicate their agreement. Other people told us they knew about their care/support plans and were happy with them.

The provider had a complaints procedure which was made available to people supported by the service in an easy read format. We saw copies of the complaints procedures in the care records we looked at. One of the staff we spoke with said the complaints procedure was at the back of everyone's care file in their home. They added they would support people to make a complaint if they were not happy with the service.

One person who was supported by the service said, "I would never complain about Affinity because they are good." Another said, "It is really good here. If I had any concerns I'd tell the staff. If it was one of the staff who made me unhappy then I'd tell the manager. She's great."

Some of the people we spoke with were not sure if they had received written information about the complaints procedures. However, they all stressed they were totally happy and many said they thought the service was excellent. The provider's quality assurance questionnaires included a question about the complaints procedures which served as a reminder to people that there was one available.

There were no open complaints at the time of the inspection. The complaints records showed that previous complaints had been dealt with in accordance with the provider's procedures and had been resolved to the satisfaction of the people involved.

Complaints were monitored by the senior management team to make sure they were dealt with in an appropriate and timely way. The provider also kept a record of compliments and good news stories. Recent good news stories showed one person had been supported on holiday to swim with dolphins and another had been supported to move into their own accommodation.

Good

Is the service well-led?

Our findings

We found the people who were supported were at the heart of the service. For example, in the supported living houses there were meetings where the people supported were given the opportunity to have a say in how the service was delivered. In another example the provider held a quarterly Parent/Carer Forum and we were told they were well attended and helped to ensure people's families and carers were actively involved in how the service operated.

The provider sent annual quality assurance questionnaires to people who were supported by the service, families and carers, professionals and other stakeholders and staff. These included easy read surveys for people supported by the service. The survey results were analysed and people were given feedback on the overall findings and any actions taken or planned. For example, the information was shared at the Parents/Carer forum. In addition the registered manager told us they carried out telephone surveys with people who were supported by the outreach service.

There was also a Staff Forum, a quarterly staff newsletter which was made available in an electronic and paper format and regular staff team meetings. Staff told us they liked working for Affinity Trust and said morale was good. One support worker said, "They are really keen on training and development. I get good feedback on a regular basis and that helps morale as well." Another said, "They are very good in offering training. I've done a lot of stuff on the MCA and safeguarding and the company do put the people at the heart of things. They are very flexible as well." These views were echoed by other staff who spoke very highly of the registered manager and division director. For example, staff said they provided strong leadership and always worked in the best interests of the people they supported.

There was a clearly defined management structure in place. The registered manager was responsible for the day to day running of the service and managed a team of four support managers, two for the outreach service and two for the supported living services. The support managers covered geographical areas, for example the outreach service was made up of two teams, one covering Shipley, the other covering Ilkley and Keighley.

The local management team was supported by a senior management team which included a division director who covered the north of England and health and safety and quality managers who had national roles.

The provider had systems and processes in place to monitor and assess the quality and safety of the services provided.

The registered manager was required to visit each of the supported living properties every two months and visits followed a set format. This included people supported by the service, staff, the environment and finances. The visits were recorded on the provider's electronic monitoring system and were flagged up if not completed. For the outreach services the visits had to be carried out every six months.

There was a schedule of audits which included care/support plans, finances, health and safety and medication. In addition, support workers and supported managers had schedules of checks and audits which they were required to complete a weekly or monthly intervals. All of these audits and checks were monitored by the senior management team to make sure they were done and any shortfalls found were dealt with. This helped to make sure the service was delivered safely and people consistently experienced good quality outcomes.