Adolphus Care Ltd

Adolphus Care

Inspection report

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Website: www.adolphus.org.uk

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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

This inspection took place on the 11 April 2018 and was announced.

Adolphus Care provides support to people with learning disabilities and mental health needs. The service supports people living in six 'supported living' settings so people can be as independent as possible. People's care and housing were provided under separate contractual agreements. Hibiscus Properties Limited provided the housing and maintenance and Adolphus Care provided the care and support to people using the service. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using Adolphus Care received a regulated activity. CQC only inspects the service being received by people provided with 'personal care' and help with tasks related to personal hygiene and eating. Where people do receive this service, we also take into account any wider social care provided. At the time of the inspection only one person was receiving support with a regulated activity, but we also looked at the wider social care provision at the service.

At our last inspection in April 2016 we rated the service good overall but requires improvement in Well Led because a registered manager was not in post. At this inspection we found the evidence continued to support the overall rating of good, with the key question 'Is the service Well Led?' also being rated good, as although the previous registered manager had left the service in January 2018, the current manager was in the process of applying to become the registered manager. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

During the inspection we found there was not a registered manager in post but the manager had applied to the Care Quality Commission to become the registered manager.

The provider had procedures in place to protect people from abuse. Support workers we spoke with knew how to respond to safeguarding concerns. People had risk assessments and management plans in place to minimise risks and incidents were recorded appropriately.

Support workers had up to date relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service. Safe recruitment procedures were followed to ensure staff were suitable to work with people using the service.

Medicines were managed safely and support workers had appropriate training and competency assessments.

Support workers had completed training in infection control and used appropriate protective equipment so

they could reduce infections and cross contamination.

People's needs were assessed prior to moving to the service. Dietary and health needs were assessed and recorded so these could be met.

Care plans provided appropriate information to meet people's day-to-day health needs and people were supported to access healthcare services appropriately.

People were supported to have maximum choice and control of their lives and support workers were responsive to individual needs and preferences. However the provider had not specifically discussed end of life wishes with people, but agreed to do so as part of future care planning.

We observed people were treated with respect, were involved in planning their care through one to one sessions and could make day to day decisions. Care plans contained the required information to give support workers guidelines to care for people in their preferred manner.

There was a complaints procedure in place, and people told us they knew how to make a complaint if they needed to.

Feedback indicated the manager fostered an open culture and positive communication. People using the service and support workers told us the manager was available and listened to them.

The service had systems in place to monitor, manage and improve service delivery to improve the care and support provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	Good
Is the service effective? The service remains Good.	Good
Is the service caring? The service remains Good.	Good
Is the service responsive? The service remains Good.	Good
Is the service well-led? The rating changes to good because although there is not a registered manager in post, the current manager has applied to CQC to become the registered manager.	Good

Adolphus Care

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 was a comprehensive inspection. The inspection took place on 11 April 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location was a small supported living service for people who are often out during the day. We needed to be sure that they would be in. The inspection was undertaken by one inspector.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding and commissioning teams to gather information about their views of the service.

During the inspection we spoke with two people using the service, the manager and three support workers. We observed the care and support being delivered to help us understand people's experiences of using the service. We viewed the care records of two people using the service and seven staff files that included recruitment and training records. We also looked at medicines management for one person who used the service and records relating to the management of the service including service checks and audits. After the inspection we spoke with one more support worker.

Good

Is the service safe?

Our findings

There were systems in place to help safeguard people from abuse. Safeguarding policies and the whistleblowing policy were up to date. One person told us they felt safe living in their home. One support worker told us, "The staff stay safe with policies and risk assessments around them. We have safeguarding training and encourage [people using the service] to talk to [staff]." Another said if they had a safeguarding concerns, "I would speak to a senior or management and if no action is taken, to [the local authority] safeguarding team."

We saw where safeguarding alerts were raised, the provider took appropriate action, by recording the incident, the action taken, what other agencies they notified, including the Care Quality Commission, and any correspondence with the local authority completing the investigation. Safeguarding alerts were recorded on an online system that generated a report for discussion at managers' meetings.

Where there were risks to people's safety and wellbeing, these had been assessed. Risk assessments were carried out on line using software to score them. If there was a high score, the manager was notified. The manager told us most risk assessments were for long term risks such as accessing the community independently, for example by independent travel or taxi.

Risk assessments we saw included the hazard, how to control or manage it and the action to take to reduce the risk. We saw risk assessments and management plans that included epilepsy, personal hygiene and verbal aggression. The risk assessment record was signed by the person using the service and a manager.

Feedback from one local authority indicated risk assessments were not always robust enough. To support the risk assessments, the manager was introducing 'working guideline' forms and we saw one for a person who did not receive a regulated activity. The document recorded who was affected by the activity or behaviour, an objective, associated risks and detailed guidance for support workers on how to manage the activity or person's response. The manager was in the process of completing these for all people using the service.

We saw incidents were recorded appropriately that included details of the incident, actions, outcomes and any additional notes, for example when a social worker visited in response to the incident. Incidents and accidents were discussed at weekly managers meetings and the provider was in the process of implementing a tracking system on line.

The provider had a finance policy and if they held petty cash for people, money in and out was recorded and receipts kept. The cash bags were sealed with money clips and stored securely.

The provider used a team of care staff, long term bank and some agency staff. At the time of the inspection they were recruiting support workers and planned to take on a student social worker.

The manager told us they were getting a new software package for rostering staff to streamline some tasks.

Not everyone received 24 hours support and the actual service they received was based on the amount of hours the local authority commissioned for the person using the service. The manager told us they had met with people using the service to ask how they would like their support to be allocated and the roster was created around people's feedback. Rosters were designed to accommodate one to one support sessions including key working sessions, household tasks and appointments. The manager or the senior attended more significant appointments. Additionally the provider had a 24/7 on call service shared between the manager and seniors so support workers always had access to support from a manager.

We looked at seven support worker records and saw the provider had systems in place to ensure support workers were suitable to work with people using the service. The files contained checks and records including applications, gaps in employment declaration, interview records, two references, identification documents, Disclosure and Barring Service criminal record checks and lone worker risk assessments.

Medicines were kept in a locked cabinet. There was a staff signature sheet and the medicines administration records (MAR) were signed correctly. Information taken from The National Institute for Health and Care Excellence (NICE) guidelines was on display for the staff along with listed medicines regularly taken by people using the service and what the medicines were for.

The provider had a medicines policy that included PRN (as required) medicines administration guidelines and people's care plans listed all medicines with directions, dosages and the reasons for taking the medicines. One person said, "They give me seven or eight tablets and then at night the same."

We saw medicines observations and assessment forms for support workers which included a tick list for the observation and a written assessment for support workers to complete. This was undertaken annually or sooner if the support worker required further training.

We also saw weekly medicines audits which indicated medicines were being administered safely.

Support workers had completed infection control training and told us about keeping cleaning equipment separated and cleaning materials safely stored. They also said they used hand gels and gloves.

Good

Is the service effective?

Our findings

People's needs were assessed prior to moving to the service. People using the service were referred by a local authority, the manager looked at the local authority's assessment and if they thought they could meet the person's needs, they met the person and completed an initial assessment with them. The manager had recently updated the initial assessment template to bring it in line with the current legislation around the Care Act 2014. Feedback from two local authorities indicated some assessments could be more robust but also that "the organisation manages some transition clients effectively" and that a "recent review showed positive feedback with good interventions by staff." The manager told us as they had a number of young adults in the service, they were planning to appoint a transition worker to support people using the service with the transition from children's to adults' services. The manager felt this would support the assessment process to be more robust. After the initial assessment the person was invited to visit the supported living setting and after they moved in, they receive a tenancy and a support agreement. The manager told us if the person wanted family and friends to be involved in the process they were.

The assessment form included personal details for the person, medical information, any physical concerns, how the person communicated, what other agencies were involved with the person's care, their family and social network, finances, personal care and activities. Risks were also assessed and a recommendation was made about the person's suitability for the service.

Support workers undertook training the provider considered mandatory such as safeguarding adults. This helped to provide support workers with the skills and knowledge required to deliver effective care. All support workers attended an annual three day non-abusive psychological and physical intervention (NAPPI) training course which provided strategies to de-escalate situations and manage behaviour that challenges. The provider offered the course twice a year and the next course was due in June 2018. Other relevant courses included epilepsy and autism training delivered by specialists, medicines training through eLearning and a pharmacist and safeguarding training accessed through the local authority. The manager told us they were in the process of arranging training around mental health needs and personality disorders. Support workers told us the training they had completed was relevant to the people they were supporting and included challenging behaviour, NAPPI, autism, incontinence and epilepsy training.

The manager was also in the process of rolling out the Care Certificate to new staff and then to longer standing members of staff. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to care workers roles and responsibilities within a care setting.

We saw new support workers undertook an induction and probation period that was reviewed. One to one supervisions were held every six weeks. A number of topics were discussed including work performance, key working and policies and procedures. Appraisals were held annually. The manager also completed supervisions and appraisals with long term agency staff.

People we spoke with said they received support with food and drink preparation and told us they were satisfied with the support provided. One person we spoke with said, "I like the food." A support worker said,

"Because this is supported living, [people] have choices. They are independent so we encourage them to eat healthily but they can make their own choices. We go shopping with them." Food allergies and dietary likes and dislikes were recorded in the care plan. We saw one person's care plan under 'nutrition' had been changed several times to reflect the type of meals they wished in the evening.

Support workers told us they worked well together and there was good communication in the service. Handovers were written down for clarity, there was a communication book for day to day information, staff read people's daily logs when they came on shift and emails and the intranet were in use. Support workers were required to sign they had read information that was important and initial the communication book to confirm they had read it. One support worker said, "Team work is good. We support each other. Any time there is an issue, the manager is here to support us and put us on training."

Care plans provided appropriate information to meet people's day-to-day health needs. The registered manager told us they were in the process of developing bespoke health passports for people using the service that could be used for any medical appointments or admissions.

People could choose how to decorate their flats. We saw in one person's room they had been able to create an activity they were interested in. This affected the decoration of the room, but the provider was happy that the person should be encouraged to continue this particular interest.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People consented to the care provided as part of their support agreement. The manager told us they were reviewing this in line with the new General Data Protection Regulation (GDPR) regarding data protection and privacy for all data changes. We saw in one person's file a mental capacity assessment was completed by the local authority and a best interests meeting held to determine they did not have capacity to manage their finances.

Care workers we spoke with had completed Mental Capacity Act training. Comments around how they applied the training to their work included, "Consent is all about the service users. Even if they have DoLS to protect them, even if they do not have capacity for one thing, like money, it doesn't mean they don't have the capacity [to make decisions] for something else" and "You shouldn't make decisions for people. Even if they do not have capacity, they can make some decisions."

Good

Is the service caring?

Our findings

People were treated with kindness and respect and we observed positive interaction between support workers and people using the service. Support workers were aware of people's interests and triggers around behaviour and responded accordingly. Comments from people using the service included, "Very nice people. They talk to me. I get on well with all the people here" and "They help me out if I need help and they ask me if I need help."

People's care plans recorded their cultural and religious needs and provided some background history. People were able to express their views and were involved in planning their care, for example through one to one key working sessions and residents' meetings. Support workers we spoke with understood people should be involved in making decisions. A support worker told us that the previous week one person asked if they could be supported to go to church and this was arranged, so he was able to attend the service as he wished. Another support worker said, "[Person A] and [Person B] can both choose what they want to do. [Person A] doesn't like to go to the shops but we sit with them and ask what they like [for us to buy]. [Person B] will go with staff to the shops. It's their choice." Others said, "I work according to what [people using the service] say and their care plan" and "What I understand about support is not doing for them but understanding how to help them to do what needs to be done. Everyone is different." Additionally we saw laminated pictorial aids for people to help with communication. Examples included various emotions and music being too loud.

People using the service lived in their own flats and received a set amount of support hours each day with the aim of promoting their independence and living skills. One support worker told us how people were supported to travel independently and a mobile phone was used as a means of minimising risk when the person was out independently. Another support worker said, "Anything I support them with, I get them as involved as possible. For example, I will start cleaning their room, they join in and I can stand back."

Good

Is the service responsive?

Our findings

The manager told us care plans were live documents and therefore continually changing to meet people's changing needs. Most people did not want to sit down with support workers to review their care plans but people were involved through general conversations and one to one key working sessions. One person we spoke with said, "I do get key working sessions. I talk to [support worker] about my problems and everything." This was supported by minutes of key working sessions we saw.

People's care plans identified how they wanted their care and support to be provided. One page profiles recorded their likes and dislikes and provided social background information about the person. There was a summary of the care plan in addition to fully completed sections that provided information on the current situation, expected outcomes and actions required to achieve the outcomes.

As the service provided supported living, each person signed a care support agreement, which detailed the provider and the person's expected responsibilities in the service. The document was both written and in a pictorial format and was signed by the person using the service and the provider.

In the office, there was an activity planner on the wall that included the support hours that people required and any appointments they had to attended. We saw that one person came in and put their own activities on the board, which indicated they had a choice about how they wanted their day to go. Care records recorded activities such as employment or education as short and long term goals. The manager said they considered activities important because they provided some structure which could be difficult in supported living. The service employed an activity co-ordinator to support people to find activities that were meaningful to them.

In addition daily logs were recorded on line and were broadly task orientated but indicated people were receiving support in line with their care plans.

The provider had a complaints policy, an easy read complaints document and a booklet for people using the service to explain how to make a complaint. The complaints form included what happened, the desired outcome of the complainant, actions taken and the follow up. Comments from people using the service included, "No complaints from me" and "If I say a complaint they give me a form and staff help me fill it out and they bring it to the manager. They normally do help."

The service did not provide end of life care and the manager told us as most people living at the service were younger adults, they had not specifically discussed end of life wishes with people. However they agreed to do so as part of future care plans.

Good

Is the service well-led?

Our findings

The service promoted an open culture which was inclusive. We observed the manager interacting with people using the service and this was done in a respectful way with a clear understanding of their needs. Support workers told us, "[The manager] is always there. You don't have to wait. [They] are always on hand", "I most definitely feel supported. Anything I'm not sure of or anything I need help with, [manager] is always there", "[Manager] supports me a lot. They are there for me any time I need help" and "[Manager] is a problem solver. You don't have to sit around and wait for something to get done."

At the time of the inspection, the service did not have 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. The last registered manager left in January 2018 and at the time of the inspection the new manager had submitted an application to CQC to become the registered manager. The new manager had been with the service for ten years and during that time had completed a human resources course and qualified as a social worker. To keep up with best practice they attended provider forums for three different local authorities and relevant conferences. The manager told us, "I have a passion and personal experience of family who use services."

Team meetings were held regularly and all staff participated. One support worker said, "Team meetings are good to be all in one place with everyone. Get to voice concerns and get feedback from other people. Always room for improvement. I always walk away having learnt something."

Managers meetings were also held once a week. Weekly reports were sent from each of the service's supported living settings and these were raised as part of the discussion of each person using the service. The reports included incidents, accidents and safeguarding alerts. A senior support worker told us these meetings were helpful as it meant all the senior staff knew what was happening across the service and this was useful for supporting the 24/7 on call system. We saw minutes from managers' meetings included a discussion about each person using the service and where required an action against the discussion. There was a summary of actions at the end of the minutes and these were reviewed at the next meeting. This meant the management team had a good overall view of how the service was running and the opportunity to address issues and improve service delivery.

The provider had last completed satisfaction surveys in 2016. Eight out of twelve people responded and the analysis was displayed in each of the settings and staff surveys were discussed at the managers' meetings. They did not complete surveys in 2017 but had sent out surveys in March 2018 which they were waiting to receive feedback from. The manager told us they tried to show appreciation for the work their staff had done through a staff awards ceremony held at Christmas time, and staff meals and outings.

Policies and procedures contained relevant legislation and guidance for good practice and the manager notified the Care Quality Commission of events and incidents that occurred within the service as required.

The provider had a number of data management systems in place such as audits for medicines and a training data base for support workers. The manager had also completed a comprehensive quality assurance inspection in October 2017 that included ensuring incidents and safeguarding alerts were correctly recorded, gathering the views of people using the service, evidencing activities taking place, inspecting the kitchens and menus and auditing people's care files, staff files and medicines records. The next inspection was due imminently. The audits and checks provided the manager with an overview of the service so they could respond to issues, minimise risks and improve service delivery.

We saw evidence that the provider worked with a number of other professionals including mental health teams, social workers, GPs, local authorities, drug and alcohol services, community psychiatric nurse and the continence nurse to help provide care and support to people.