Alexander's Supported Living Ltd

Alexander's Care and Support Agency

Inspection report

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Date of inspection visit:
08 May 2018

Date of publication:
11 June 2018

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 took place on 8 May 2018 and was announced to ensure staff we needed to speak with were available. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. This service also provides care and support to people living in 12 'extra care' houses, which are adapted single household accommodation. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The agency provides a service to younger adults, older people, people living with dementia, people with learning disabilities or autistic spectrum disorder and people with a mental health diagnosis. They also provide care to people who misuse drugs and alcohol, people with an eating disorder, people with a physical disability or sensory impairment. The service provides care to 60 people, at the time of the inspection nineteen of these people received the regulated activity of personal care, therefore only their care was included within the scope of this inspection.

The service had a registered manager this 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.

Staff had undertaken relevant safeguarding training and understood their role to protect people from the risk of abuse. Potential risks to people had been identified, assessed and measures were in place to minimise the risk of their occurrence. People received their medicines from competent, trained staff. Relevant processes and procedures were in place to ensure people's medicines were managed safely. People were protected from the risk of acquiring an infection. Processes were in place to review incidents and to identify any changes or learning required for people.

The provider operated robust recruitment procedures to ensure staff's suitability to work with people. There were sufficient staff numbers of staff deployed to meet people's needs and flexibility if people required additional care. Staff underwent an induction to their role and received on-going training appropriate to their role. Most staff had also achieved a professional qualification in social care.

Staff completed pre-admission assessments with people to determine if they could meet the person's care needs. Staff had access to information about current standards, legislation and guidance to enable them to provide people with effective care.

Staff worked with a range of other statutory and non-statutory agencies in the provision of people's care. Staff supported people to live healthier lives and to have access to healthcare services. People were supported where required to ensure they ate and drank sufficient for their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People reported they enjoyed positive, kind relationships with staff. Staff understood how to build relationships with people and spent time with them. People were encouraged to participate in making decisions about their care. People's privacy and dignity were respected and promoted in the provision of their care.

People reported the service was responsive to their needs. People had care and support plans in place that identified their care needs and how these were to be met. Staff understood people's care needs. Staff recognised that people living with a mental illness could find it more difficult to have a structure to their day or might experience social isolation and action had been taken to address this. People were provided with opportunities to participate in a range of activities, including in their local community. Staff had worked with other agencies to ensure people nearing the end of their life received appropriate care.

The registered manager promoted an open culture where people and staff felt able to speak to them about any issues as they arose. There was a clear management structure in place. Staff had a clear understanding of their role and individual responsibilities. People were provided with information about how to make a complaint. Any complaints received were logged and investigated in order to identify any areas of improvement for people.

People were very involved with the service. They worked jointly with staff on mental health awareness initiatives in the local community, fund raising and had input into the service via the service user representative and service improvement plan.

People their relatives and professionals had been sent a quality assurance survey to ask their views on the service and the responses showed there was a high degree of satisfaction. The registered manager and the operations manager also regularly audited the service in order to identify potential areas for improvement.

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.

Processes and procedures were in place to protect people from the risk of abuse. Processes were in place to identify any learning points following incidents and these were shared with staff.

Risks to people had been identified and assessed with them. Plans were in place to manage identified risks to people where possible.

There were sufficient numbers of suitable staff to meet people's care needs.

Processes, policies and staff training were in place in relation to medicines management for people.

Processes, policies and staff training were in place to protect people from the risk of acquiring an infection.

Is the service effective?

Good

The service was effective.

People's needs had been assessed and their care and support was based on current legislation and guidance.

Staff were provided with an appropriate induction, on-going training, supervision and opportunities for professional development.

People were supported by staff where required with preparing their meals.

Staff worked both together as a team and with other agencies in the provision of people's care. Staff supported people to have access to healthcare services.

People's consent to the provision of their care had been sought.

Is the service caring?

Good

The service was caring.

People were treated by staff with kindness, respect and compassion.

People's views were sought and they were involved in decisions about their care.

People's privacy and dignity were respected and promoted in the provision of their care.

Is the service responsive?

Good

The service was effective.

People's needs had been assessed and their care and support was based on current legislation and guidance.

Staff were provided with an appropriate induction, on-going training, supervision and opportunities for professional development.

People were supported by staff where required with preparing their meals.

Staff worked both together as a team and with other agencies in the provision of people's care. Staff supported people to have access to healthcare services.

People's consent to the provision of their care had been sought.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive culture within the service. There was a clear management structure for the service.

People and staff were engaged and involved with the running of the service.

Processes were in place to monitor the quality of the service people received and to identify potential areas for improvement.

The service worked in partnership with other agencies to meet people's care needs.

Alexander's Care and Support Agency

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We gave the service 48 hours' notice of the inspection to ensure staff we needed to speak with were available and to enable the service to inform people the inspection was taking place and that they may be contacted. Inspection activity started on 3 May 2018 and ended on 8 May 2018. It included telephone calls to people and a home visit. We visited the office location on 8 May 2018 to speak with staff; and to review people's care records and policies and procedures.

Prior to the inspection, we spoke with a commissioner of the service. During the inspection, we pathway tracked the care of four people. Pathway tracking is about capturing the experiences of a sample of people who use a service, by following the person's route through the service and getting their views on it. We also looked at a further care plan and spoke with another five people about their care.

We spoke with four care and support workers, three team leaders and the registered manager. We reviewed three staff recruitment and supervision records. We also reviewed records relating to the management of the service.

This service had not been inspected since there was a change in the legal entity that provided the service and therefore it was due a comprehensive inspection. The inspection was also prompted in part by the notification of an incident. This is subject to investigation and as a result this inspection did not examine the circumstances of the incident. The inspection reviewed any potential on-going risks to people using the service who receive the regulated activity of personal care.

Good

Is the service safe?

Our findings

People felt safe with the care staff provided. Their comments included, "We get a carer every day. They come in the morning and the evening," "Staff stay the full time," "Calls are roughly at the same time and staff stay for the full half hour," "I have four regular carers" and "I get continuity [of staff]." People also told us, "They come and give me my tablets", "Staff help me with my medicines and remind me" and "They fill in the medicines form and I countersign it."

Staff us told us they had undertaken safeguarding training that they updated annually, which records confirmed. Safeguarding people was discussed with staff at their meetings and staff had access to relevant polices and contact numbers. Staff were able to describe the purpose of safeguarding and understood their role in keeping people safe from the risk of abuse. A staff member was able to tell us about the measures they had taken to safeguard a person. Arrangements were in place to enable people to store their money securely where they required this support and wanted it. There were processes in place to ensure staff could account for people's money. People were provided with information about how to keep themselves safe. The registered manager recognised that the people they provided care to were more vulnerable to experiencing, 'Hate' or 'Mate' crime. Hate crime is when people are targeted due to their disability and mate crime is when people are befriended or groomed for exploitation and abuse. Staff had engaged the local police community support officer to meet with people about 'Hate' and 'Mate' crime for their personal safety. Processes and procedures were in place to protect people from the risk of abuse.

A range of generic risks to people had been assessed. These included risks from their: mental state, medicines, skin, vulnerability, bathing, eating, fire, substance abuse, electrical equipment, challenging behaviour and neglect. Individual risks to people had also been identified. Where there was a risk to a person, the severity and likelihood had been assessed and control measures documented that would reduce the likelihood of occurrence. People signed their risk assessments which demonstrated they had been involved in discussing and agreeing their content. People's environments had been risk assessed, in order to identify any potential risks to people during the provision of their personal care. People's care records contained their photograph and a physical description of them in the event they went missing and their details needed to be passed to the police.

Staff said they could access guidance from senior staff out of hours during evenings and weekends and people also had contact numbers for staff support. The registered manager provided examples of when people had contacted the out of hours late at night, as they required support, which staff had provided. Potential risks to people had been identified, assessed and measures were in place to minimise the risk of their occurrence.

The provider had undertaken appropriate checks before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS), to ensure staff were of suitable character. There were also copies of other relevant documentation including applicant's full employment history, references and confirmation of their fitness to work. Staff confirmed they had undergone recruitment checks prior to their employment. The provider operated robust recruitment procedures to ensure staff's suitability to work

with people.

People had been consulted about their preferred time of care calls and these were documented. Staff told us, "[Name of registered manager] tries to match staff to people." The registered manager told us how a person did not want to work with a staff member and had chosen another whom they felt comfortable working with, which staff confirmed.

Staff were either rostered to support people in the shared houses on a staff shift or to work with those living in the wider community. This ensured an effective deployment of staff. There were sufficient staff employed to cover any additional calls people required or unforeseen staff absence. Staff told us that, as lone workers, they had to text the office when they arrived at care calls and when they left to ensure their whereabouts were known. Staff also completed logbooks located in people's homes, which documented the time and duration of their visit. People countersigned the visit records.

Staff told us they had completed medicines training and that their competence to administer people's medicines had been assessed, which records confirmed. Staff had access to relevant policies and procedures to provide them with guidance on the management of medicines.

People's records contained an up to date record of their medicines. Their care and support plans provided information for staff about how they should support people with their medicines where they required this support. Care plans detailed the arrangements for ordering and delivering people's medicines. Arrangements were in place to ensure the secure storage of these medicines before staff took them to people. There was not a risk assessment in place as required to assess any associated risks with this storage of people's medicines. Following the inspection the registered manager submitted a risk assessment to demonstrate that they had assessed any risks. In the shared properties, people were encouraged to store their medicines in the locked cabinets provided. This ensured that where people shared their property with others, they had facilities to store their medicines safely with their agreement.

Risk assessments had been completed for people who did not need staff support to look after their medicines. These had been signed by the person, staff and a health care professional to demonstrate that it was safe for the person to do so and jointly agreed.

People's medicine administration records (MARs) reviewed were complete. Staff audited five different people's MARs on a weekly basis, to check for completeness.

Staff told us they had undertaken infection control training, which records confirmed. Relevant policies and guidance were available. Staff told us they wore gloves and aprons when they provided people's personal care and we saw that these were readily available for them in the office.

When incidents occurred, an incident form was completed by staff, which documented the actions taken in response to the incident and relevant investigations were completed. A central log was also maintained of all incidents, the actions taken and who had been informed. Where people's care plans needed to be updated following incidents, this had been recorded. Staff told us, "We get an update on any changes after an incident." Processes were in place to review incidents and to identify and changes or learning required for people.

Good

Is the service effective?

Our findings

People told us the service was effective. Their comments included, "They came and did an assessment with my Social Worker," "They [staff] understand my illness," "Staff have helped me to get better," "They make sure I have food" and "Staff help me with cooking." People also told us, "Staff help me to book appointments if I need them to" and "They help me with doctors' appointments." A person told us their healthcare professionals set targets for staff to work on with them to enable them to regain their independence, which staff followed.

People or the professional who had referred them to the service were required to complete a referral form to the service, providing background information about the person, before a pre-admission assessment was completed by senior staff with the person. This ensured staff had gathered relevant information that was available about the person for them to determine if they could meet the person's care needs effectively.

The registered manager told us the provider subscribed to a number of legislation update services and that information received was then communicated to other staff to ensure staff had access to up to date information. Staff had access to relevant information such as National Institute for Clinical Care Excellence Guidance (NICE) on managing medicines in the community and infection control. Staff used the 'Mental Health Recovery Star' with people which is a tool designed to support people in managing their own mental health and when recovering from mental illness. Staff had access to information about current standards, legislation and guidance to enable them to provide people with effective care.

Staff told us that when they commenced employment they had received an induction to their role and shadowed the work of more experienced staff before they were rostered to work with people, which records confirmed. Staff who were new to social care were required to complete the Care Certificate. This is the minimum set of standards that health and social care workers are required to attain to prepare them for their work in social care. Staff had also completed training in managing people's behaviours which could challenge staff. In addition to the provider's required training, staff had undertaken additional training relevant to the care needs of the people they supported. This included the areas of: mental health, drugs and alcohol, dementia and learning disability.

The registered manager told us once staff completed their required training they undertook additional training related to the needs of the people they cared for, which records confirmed. A staff member told us, "We get good training, [including] dementia and Schizophrenia." Staff had access to information and guidance about the mental disorders that those they cared for were living with. Staff were also able to access information and guidance about the street drugs that people might use. Staff had access to relevant information to enable them to carry out their role effectively.

Staff told us they received regular supervision of their work both through one to one supervisions and observations of their practice with people, which records confirmed. They also received an annual appraisal of their work, in order to enable them to reflect on their work over the past year and to identify their development needs for the forthcoming year. Eleven of the thirteen care staff had either achieved or were

studying for a recognised professional qualification in social care. Staff were supervised and supported with their on-going professional development.

Where staff supported people with the provision of food and drink, this was noted in the person's records and staff were instructed to ask the person what they wanted. Staff ensured that people could access meals between their care calls. Staff supported people where required to shop and prepare their own meals. Staff had access to recognised assessment tools to enable them to assess the risk of a person becoming malnourished if required.

Staff worked both together and with a variety of external services in the provision of people's care. Records showed staff had supported people to see a range of health care professionals in relation to both their mental and physical heath. Staff worked with other agencies in the provision of people's care.

Where people lived with health conditions such as diabetes, there was information in their care plan for staff about their type of diabetes, how this was managed and the signs and symptoms that would indicate the person was becoming unwell and that medical assistance should be sought. Staff had been required to read relevant information about how to support people with their diabetes care.

Where guidance had been provided by health care professionals about the care and support people required this had been added to their care plan to instruct staff. A person's care plans instructed staff to promote healthy eating with the person. Another person told us, "Staff are helping me to lose weight, we go for walks." They also told us how staff supported them to monitor their weight monthly.

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.

Staff had undertaken MCA training and told us that everyone who currently received care had the capacity to consent to the care provided. People had been consulted about their care plans and risk assessments and had signed their agreement to their content. Staff had access to guidance and to the local authority MCA assessment tool in the event they needed to make a MCA assessment for a person in respect to a specific decision.

Good

Is the service caring?

Our findings

People told us the service was caring. Their feedback included, "Staff are caring and kind," "They are wonderful. They are interested in me," "We chat about the news and what is on the TV," "They [care staff] always ask is there anything else I can do before I go," "We get on alright," "Carers are polite and kind," "They are very helpful" and "All the staff are brilliant." People also told us, "They [staff] consult me about my care," "Staff respect my independence," "I am trying to get independent and they [staff] are helping," "Staff ensure my dignity is upheld" and "They understand my difficulties." A person told us how sensitive staff were to their personal care needs.

People's records provided information about their background and their preferred term of address to inform staff about the person. A staff member told us, "We build relationships with people by being open with them." The quality of staff's interactions with people was regularly assessed during staff's observed practice supervisions. Staff were assessed on whether the person was 'comfortable' with them and how well staff involved the person. We observed people experienced positive relationships with the staff who provided their care. They were relaxed and happy in the company of staff and enjoyed chatting to them.

Staffing arrangements enabled staff to spend time with each person in line with their needs and to work at their pace. People told us they did not feel rushed by staff during the delivery of their care.

People had been provided with a copy of the service user guide and the provider's statement of purpose. To provide them with information about the service upon which they could base their decisions.

People's records noted if they wished their relatives to be involved in their care planning. They were also asked to consent to the sharing of information where required with relevant others. It was noted if people required an advocate to represent their views.

People's care plans described for staff how the person was involved in deciding how they wanted their care provided. A person told us, "I choose a wash or a shower." Staff told us, "I listen to people and how they want something done. You encourage people but respect their wishes."

Staff were able to tell us about how they ensured people's privacy and dignity were maintained during the provision of their personal care. There were written instructions for staff about how to uphold people's' dignity in the provision of their personal care. Staff were assessed on how well they upheld people's dignity during their observed practice sessions.

People's care plans promoted their independence by informing staff to prompt people where they required this support so that they could do things for themselves. For example, prompting people with their personal care, meals and attendance at activities. A person told us how staff encouraged them to be independent with those tasks they could undertake for themselves.

Good

Is the service responsive?

Our findings

People told us they felt the service was responsive. Their comments included, "They [staff] asked me about my history," "They do reviews [name] or the manager will ring and come and visit me," "They are very flexible with times," "Carers understand my needs," "They [staff] work with us on our goals from our Outcome Stars" and "We went for a picnic today." A person told us they did have an afternoon call but this had stopped as they no longer needed it, whilst another person told us they received extra care if required.

People had care and support plans in place that reflected what their identified care needs were, the aims and objectives for the delivery of their care and an action plan of how this was to be achieved. Staff told us how people each had a keyworker who sat with them and drew up their care plan. These were then reviewed and updated as people's needs changed. A keyworker is when a staff member has responsibility for a person's care.

People had mental health care plans in place, which identified their personal triggers, early signs and symptoms of relapse and the action staff should take to support the person. These were then reviewed monthly with people to ensure they still addressed the person's needs.

Staff told us they received any updates about people or information about new people at the staff shift handover or staff meetings. A staff member told us there was a "good flow" of information about people, to ensure they had access to up to date information. Staff were also required to read people's daily care logs on arrival for their call. A staff member confirmed, "I always read people's notes." Staff kept up to date with changes in people's care.

People's records demonstrated that the provision of their care was focused on them as an individual and not just focused on the completion of tasks. Staff told us they spent time speaking with people about their interests as they provided their care and were knowledgeable about people's backgrounds and interests. They were also able to tell us about who needed more practical support and those that required more emotional support. Staff understood people's care needs.

Staff told us they reported to the registered manager if people required more support and records showed people's care had been increased where required in agreement with them or the commissioners.

Staff told us how they supported people where required to visit the local community, visit places of interest, to go shopping and to attend activities and groups. The registered manager told us that several people had been supported by staff to secure voluntary work, which a person confirmed. In addition, there was a weekly mental health group, where people could discuss issues related to their mental well-being, a weekly social activity and a weekly bible study group, which people had requested, to provide them with both structure to their week and social contact. People had also chosen to raise funds for a range of charitable causes and had arranged a number of fund raising events. Staff recognised people were more likely to experience social isolation at weekends and activities and trips were arranged, which people could join in if they wished. A staff member told us, "It is peoples' choice what to participate in."

The service ensured that people had access to the information they needed in a way they could understand and are comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff told us they had 'easy read' information for people in the event this was required. For example, there were easy read versions of the complaints policy, safeguarding and advocacy information for people.

People had been provided with a copy of the provider's complaints policy and knew how to make a complaint if they wished. People told us, "I have information about how to complain" and "I have never had to complain." We saw one complaint had been received last year from a person using the service and this had been investigated and relevant action taken.

No one currently had an end of life plan. In the event that a person was nearing the end of their life and required this care, the community nursing team would provide their clinical care. In the past, staff had worked with local services to ensure people received appropriate end of life care.

Good

Is the service well-led?

Our findings

People told us the service was well-led. Their comments included, "Yes, it is well-led," "[Name] the manager visits," "The manager comes if anything is wrong," and "I have had a questionnaire."

The registered manager promoted an open and transparent culture. People told us they could just pop and speak to the registered manager as required. A person told us, "[name of registered manager] is a good manager; I pop in for a coffee." We observed throughout the inspection people visited the office at will. Staff learnt about the provider's purpose during their induction. They told us they enjoyed working for the provider and that they found both them and the registered manager supportive. A staff member said, "If I have an issue I can come and talk" and "I enjoy working here."

There was a clear management structure in place. The service had a registered manager this 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.

In addition to the registered manager, there as a senior team leader and three team leaders to direct the staff team in their work with people. There was also a locally based operations manager who had regular contact and oversight of the service provided, to support the staff team. Staff told us, "[Name] is a fair manager" and "There is an open door policy." Staff also said the service was, "Well-led" and that "Management are supportive."

Staff spoken with had a clear understanding of their role and individual responsibilities. They were able to access both paper and electronic versions of the provider's policies in the event they needed them for guidance and were aware of how to do this.

People were very involved with the service. They produced their own newsletter to provide information about what was happening both within the service and to reflect people's achievements. People led a 'Mental Health Awareness Day' for the past three years, which aimed to tackle the stigma associated with mental health and educate the public. People and staff, had co-produced a pantomime about mental health that was performed to the local community in 2017, to promote mental health awareness and social inclusion. People also chose to support a range of charities and had arranged a number of fund raising events with staff support.

There was a service user representative whose role was to meet with new people who had joined the service and to gather views of people using the service. They met with the registered manager on a monthly basis to raise any issues for people.

People had drawn up a service improvement plan, following a meeting held in December 2017. People had agreed the activities they wanted to undertake. People had also said they wanted staff to be able to drive the minibus and for improvements to be made to the physical environment of the shared houses. The

registered manager was able to demonstrate that action had been taken in relation to all of these issues for people.

There were regular staff meetings, to enable staff to raise issues and to receive updates about people and updates.

People, their relatives and professionals were sent a quality assurance survey in December 2017 to ask their views on the service and there was a high degree of satisfaction. One person commented, "[The] team respect me and I feel able to talk with them if I need help." The staff survey also demonstrated a high degree of satisfaction from staff. The registered manager told us, "I look for staff who can do the job that little bit more."

In addition to reviews of people's care and the quality assurance surveys, which were used to assess the quality of the service people received. The registered manager completed a monthly report for the provider. This covered: hospital admissions, falls, safeguarding, complaints, compliments, diversity, incidents, accidents, staffing and training. This both informed the provider about the performance of the service and enabled them to monitor any emerging trends for people. The operations manager also completed a six monthly audit of the service. People's care plans and medicine administration records were included at each audit in addition to different aspects of the service, in order to identify any areas for improvement. For example, a central log was now maintained of all incidents, safeguarding's and complaints, following an audit, to enable the identification of any patterns or trends.

In addition to the range of statutory agencies and services staff worked with in the provision of people's care. Staff had engaged the local police community support officer to provide information for people on 'hate and mate' crime. Staff also engaged with the local community, to provide opportunities for people, for example, through voluntary work. The service worked in partnership with other agencies to meet people's care needs.