The Wilberforce Trust

The Wilberforce Trust

Inspection report

49 North Moor Road
Huntington
York
North Yorkshire
YO32 9QN

Tel: 01904760037
Website: www.wilberforcetrust.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?	Requires Improvement

Summary of findings

Overall summary

We inspected this service on 29, 30 June and 7 July 2016. The inspection was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be in the location offices and supported living services when we visited.

The Wilberforce Trust is registered to provide personal care to people living in their own homes and specialises in supporting people living with a visual impairment. Some of the people using the service also have a learning disability or physical disability. At the time of our inspection there were 31 people using the service, living across nine supported living houses and bungalows; six within York and three in Tadcaster. The Wilberforce Trust also owned the properties that people lived in, but the properties were managed separately by a facilities manager and people who used the service had a tenancy agreement.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). 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.

Feedback about the management of the service was positive and staff told us they felt supported. People using the service, and visitors that we spoke with, reported that they were very satisfied with the care provided by registered provider. We did however find that quality assurances processes were not sufficiently robust; there were inconsistences in the recording of information about accidents, incidents and issues, and a lack of evidence of audits completed and used to drive improvements. This was a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

During the inspection we found there were systems in place to support staff to appropriately identify and respond to signs of abuse to keep people safe. Risks were identified and steps taken to minimise risks to keep people safe.

There were safe recruitment processes in place so that only people considered suitable to work with vulnerable adults were employed. There was on-going recruitment and monitoring of staffing levels to ensure that people's needs were met.

Medication was managed and administered safely.

Staff received a comprehensive induction, refresher training and on-going support in their role. Staff sought consent to provide care in line with legislation and guidance, but records in relation to this could be clearer in some cases and not all staff had received training in relation to the mental capacity act. We have made a recommendation about this in our report.

People were supported to eat and drink enough and were supported to access healthcare services where necessary. Records showed that staff were following the guidance of healthcare professionals.

We received positive feedback about the caring nature of staff. Staff were observed to be warm, friendly and attentive to people's needs. People had developed caring relationships with the staff who supported them. We found people were supported to make choices and have control over the care and support they received. People also told us they were treated with dignity and respect.

Support plans contained person centred information and staff were knowledgeable about people's needs and preferences. People who used the service communicated in a variety of ways and we saw staff were familiar and adept at using people's preferred means of communication, and took account of their visual impairment.

There was a system in place to ensure people could raise concerns or make a complaint if necessary. Complaints were appropriately investigated and responded to.

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 understood how to identify and respond to safeguarding concerns to keep people using the service safe.

People's needs were assessed, risks identified and risk assessments put in place to prevent avoidable harm.

There were sufficient staff to meet people's needs and systems were in place to ensure people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to effectively carry out their roles. Staff we spoke with were knowledgeable and experienced.

Staff sought consent to provide care in line with legislation and guidance, but we made a recommendation about training and record keeping in relation to the Mental Capacity Act.

People were supported to eat and drink enough and access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

People using the service had developed positive caring relationships with the staff supporting them.

Staff effectively communicated with people using the service to support them to have choice and control over their daily routines.

People's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and person centred support plans developed to guide staff on how to meet identified needs.

There was a system in place to manage and respond to compliments and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality of care and support provided were not sufficiently robust.

Feedback we received about the management of the service was positive and staff told us they felt supported.

The Wilberforce Trust

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 registered 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 inspected this service on 29, 30 June and 7 July 2016. The inspection was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be in the location offices and supporting living schemes when we visited.

The inspection was conducted by one adult social care inspector.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought feedback from North Yorkshire County Council and City of York Council's contracts and commissioning team.

As part of this inspection we visited the location offices and two supported living schemes. During our visits we spoke with five people using the service and spent time observing interactions. We spoke with the chief executive officer, the registered manager, three group managers and four support workers. We also spoke with an induction supervisor, a human resources manager and a training co-ordinator. We looked at four people's care records, three people's medication records, three support worker recruitment files and a variety of training and staff competency check records. We also looked at a selection of records used to monitor the quality of the service. Following our visit we spoke with three relatives of people using the service.

Good

Is the service safe?

Our findings

We spoke with people using the service about whether they felt safe where they lived and people told us, "Yes I feel safe; I am happy and settled here" and "I'm safe and happy." Another person used non-verbal means of communication to show us that they felt safe with the care and support provided by staff, by using signs and nodding agreement. We observed people using the service were relaxed and at ease in their surroundings and were keen to interact with staff. This showed us that people using the service felt safe.

The registered provider had policies and procedures in place to guide staff on how to safeguard vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Staff told us they would report any concerns; one told us, "I would tell my line manager straightaway."

The registered provider had a whistleblowing policy, which enabled staff to report concerns in confidence and without recrimination. Staff told us they would be comfortable reporting any concerns, and one told us, "I wouldn't think twice about it; service user's safety is paramount. And I am confident it would be dealt with, absolutely." This showed the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

The registered manager maintained records in relation to safeguarding concerns, and we saw that appropriate referrals had been made to the local authority safeguarding team. These records showed us that safeguarding concerns were acted upon in consultation with the local authority.

The registered provider completed appropriate risk assessments in relation to people's individual needs. We saw these included assessments in relation to choking, moving and handling, medication, use of transport, falls, abuse and wheelchair use. There were also specific risk assessments in relation to individual needs, such as epilepsy and urine infections. The majority of risk assessments were reviewed six monthly, or more frequently if people's needs changed. Risk assessments documented any equipment required and the support that should be provided by staff to reduce risks and keep people safe.

We saw that records of accidents and incidents were held in a file in the office, along with any issues that had been reported via the registered provider's on-call system. There was also an electronic log kept of these accidents, incidents and issues. We found examples where appropriate action had been taken in response to accidents and incidents. We did however, find inconsistencies in the recording of accidents, incidents and issues from the on-call log.

We observed that staff encouraged and supported people to maintain their independence, whilst maintaining their safety by being attentive and providing support where necessary. The registered provider had a responsible risk taking policy, and staff gave us an example of how they used this policy with someone who was working towards increasing their independence by staying at home on their own for short periods of time. Staff explained how they were using assistive technology, including a pager linked to the smoke

alarm and doors, to reduce risk and increase the person's confidence.

We asked staff how they kept people using the service safe, and their examples included, "Before using equipment, make sure the wheelchair is safe and clean for instance. Make sure [Name] is sat square in their chair and has their lap belt on. Make sure the sling is prepared before you use it, and check people are comfortable and safe in the bath chair. Report any concerns, for example you contact the wheelchair centre for any adjustments or repairs to the wheelchairs." Staff we spoke with were knowledgeable about people's needs and the risks associated with providing their care and support.

Personal emergency evacuation plans (PEEPs) were in place for people. PEEPs are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use.

We looked at documents relating to the environment and equipment used in the supported living schemes. These records showed us that equipment, including lifts and hoisting equipment, was regularly checked and serviced at appropriate intervals. Staff conducted a range of weekly checks, including; fire alarm tests, housekeeping checks, bed rail checks, carbon monoxide detector checks, water temperature and emergency lighting checks.

We looked at recruitment records for three staff. We saw that appropriate checks were completed before staff started work. These checks included seeking two references and identification checks. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. We were advised the registered provider had made improvements to the way that recruitment checks were recorded, and we discussed seeking an additional reference where possible, when the first two references provided only contained basic information. The recruitment records we viewed showed us the registered provider was taking appropriate steps to ensure the suitability of workers.

Staffing levels varied across the supporting living services depending on the specific needs of the people living there. The registered manager told us that people's needs were assessed by the local authority who determined the level of support hours required and funded each week. The majority of these hours were shared hours to support all people living at that service, however, some were dedicated 'one to one hours' to support an individual with activities or going out. Where people had funded one to one hours, rotas reflected where these hours were used. This enabled the registered provider to ensure that people received an appropriate level of support to meet their needs.

We reviewed the rotas for the two supported living services we visited and saw that shifts were covered by staff or relief workers where necessary. Staff we spoke with told us "I feel they [staffing levels] are fine. It can be busy on an evening, but you manage. It's pretty good." We asked people using the service if they thought there were enough staff; one person told us, "Yes there are. There's always someone around." All the relatives we spoke with indicated they were satisfied with the staffing levels at their relative's home, and one told us, "I do think there are enough staff now; there's a good compliment of staff. Occasionally there will be agency staff on when I visit, who I don't know, but you have to expect this occasionally when they have staff holidays to cover etcetera."

The registered manager and staff told us that there had been a significant amount of recruitment and new staff joining the organisation since the start of the year. We were told recruitment would be on-going to fill some remaining vacancies. The registered provider had reviewed terms and conditions earlier in the year, to

retain existing staff and attract new staff. The registered provider had also worked to standardise expectations and practice across the services, so staff were able to work flexibility across more than one service where required. This showed us that the registered provider was taking proactive steps to recruit and deploy staff in order to maintain appropriate staffing levels.

The registered provider had a medication policy and procedure in place to guide staff in the safe administration of medication. Staff we spoke with told us they had training on medication management and competency checks were carried out before they were allowed to independently administer medication. We saw evidence of completed medication competency checks in staff files.

Care files contained medication support plans which documented the level of support people required to take their prescribed medication. We observed that medications were stored securely in people's rooms at the supported living services we visited. In one service we visited there was also some additional stock stored securely in the office.

We looked at a selection of Medication Administration Records (MARs). We found those currently in use were appropriately completed, to show people had received their medication as prescribed. We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs. We were told stock count checks were completed once a week and that group leaders, who each had responsibility for three supported living services, conducted spot checks on medication records. These spot checks were not recorded. Pain management plans were in place for people who required medication on an 'as required' basis for their pain management. However, we noted that the registered provider did not routinely have protocols in place for other types of medication that may be prescribed for use on an 'as required' basis, such as creams. Having a protocol in place for 'as required' medications, ensures that staff are clear when this medication is required, and in the case of creams, where it should be applied. We spoke with a group leader about this who told us they would raise this with their manager so that the registered provider could address this.

We saw that any medication errors that occurred were reported to management, investigated and recorded on the electronic log of accidents, incidents and issues. This showed that there were systems in place to ensure that people received their medication safely.

Good

Is the service effective?

Our findings

We asked people using the service if staff had the right skills and experience to do the job; people told us, "Yes they do, I think they have to go through tests" and "All the staff are very good." Visitors told us, "I am happy with the staff; they are knowledgeable" and "They are brilliant staff."

All staff completed an induction when they started in post. Initial induction training was completed over four days, and staff completed the care certificate in the first three to six months of their employment. The Care Certificate is a set of standards that social care and health workers work to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. Records showed us the induction included visual impairment training, medication, moving and handling, first aid, safeguarding vulnerable adults, fire, health and safety, epilepsy and person centred thinking. Staff who had started in the last year had also completed mental capacity act training as part of their induction. Staff also completed a range of other training specific to the needs of individuals they supported, such as tissue viability, specialist epilepsy training (buccal medication, rectal suppositories and enemas), autism awareness, managing challenging behaviours, percutaneous endoscopic gastrostomy (PEG) feeding, end of life care and dementia awareness.

Staff told us they shadowed other workers on shift until they felt confident they were ready to work on their own. Staff were also assessed for their competency after their induction, and annually thereafter, in the following areas; health and safety, medication and moving and handling.

Staff completed refresher training to ensure their knowledge and skills were kept up to date. Training was refreshed at different frequencies depending on the topic; some courses were annually and others were every two or three years. Training records were stored electronically, with copies of certificates held on file. The training co-ordinator told us there had been a significant focus on bringing all training up to date over the last year, and improving the records held about training. Records showed that the majority of staff were up to date with most of their training, but some were overdue refresher training. The training co-ordinator told us that they were in the process of writing a specific refresher course for epilepsy awareness and specialist epilepsy medication, and after this the next focus of priority would be on ensuring that by the end of the year everyone had completed any outstanding refresher training in dementia awareness, managing challenging behaviour, Mental Capacity Act, autism and person centred thinking.

Staff told us, "It's good training" and "I've completed most of my training. There was a lapse whilst the staffing restructure was going on and it felt like we hadn't had any for a while, but there has been loads this year, getting everybody back up to date." Another told us, "When I started I had an initial visit to the home to meet people. I shadowed other staff for about three weeks. In this time, I read the care plans and did my training. I then came back [to the service] to do my competencies in health and safety, using the wheelchairs and medication. [Name], the induction supervisor, followed and observed me doing medication to check my competency. I am also doing an on-line course to back up the care certificate, and have twelve weeks to complete the remaining training including safeguarding and personal care. The training has been very good."

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. We saw a system was in place to ensure that staff who were overdue their quarterly supervision meeting, had a supervision planned with their manager. Handover meetings were held in each service to exchange key information between staff. This all showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people 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 community settings applications to deprive someone of their liberty must be made to the Court of Protection. We checked whether the registered provider was working within the principles of the MCA.

We found that not all staff had completed specific MCA training, however the staff we spoke with showed an understanding of the key principles of the act and the importance of gaining consent and supporting people to make their own decisions. Mental capacity assessments completed by the local authority were held on file, and there were records of best interests meetings which were used to make a particular decision on a person's behalf where they had been assessed as lacking mental capacity.

The registered provider had completed assessments for some people in relation to their ability to manage their own finances, but they did not routinely complete their own assessments of people's capacity in relation to other specific decisions, or have a system to assess when they may need to alert the local authority to people whom they felt may be being deprived of their liberty. Whilst it was not the registered provider's responsibility to submit applications to deprive people of their liberty, having a system to identify people for whom this may be relevant would help to ensure the registered provider was taking all possible steps to alert to relevant authorities and ensure people's rights were upheld in relation to the MCA.

We found that in one of the supported living services there was evidence that the group leader had identified one person who lacked capacity and might be deprived of their liberty and they had contacted the supervisory body, in this case the local authority, for their advice, guidance and further assessment. However, this was not consistent, because in other services where it was acknowledged that some people lacked capacity and were potentially deprived of their liberty, we were told that attempts had been made to request social care assessments for these people from the local authority, but there was no clear evidence of this and no record that they had discussed with the local authority whether an application to deprive these people of their liberty was required.

In one care file we viewed there was an agreement regarding the sharing of information about a person's care and support; this stated, '[Name unable to sign so N.O.K. [next of kin] has signed agreement." There was no record of whether this relative had the Power of Attorney for decisions about the person's care and welfare, and as such there was no evidence that this person was authorised to agree to this decision on the person's behalf.

Support plans contained details about people's communication needs and recorded information about how best to engage and communicate with people to support them to make decisions. One person told us, "If I didn't want to do something they would listen" when we spoke to them about whether staff asked for

consent and respected their choices.

Overall we found that staff sought consent to provide care in line with legislation and guidance, but that records in relation to this could be clearer and some staff would benefit from additional training in the MCA.

We recommend the registered provider seeks guidance on best practice in relation to the Mental Capacity Act.

Support plans we reviewed contained detail about people's specific dietary needs, information about the food and drinks people liked and disliked and information about the support people required with eating and food preparation. People we spoke with said they had access to sufficient food and drinks and told us they were involved in decisions about the menu. People also confirmed they were supported to be involved in preparing their own meals where they were able to do so.

All the relatives we spoke with were satisfied that staff supported their relative to eat a varied diet and drink regularly. One told us that it could be particularly difficult to engage their relative to drink when they were unwell, but staff really encouraged them and knew their preferences well.

Support plans contained information about people's health needs, prescribed medications and contact details of healthcare professionals involved in supporting them. There was information about any medical conditions, for instance one support plan we viewed contained detailed information about epilepsy; the type of seizures the person experienced and how staff should respond. Seizure monitoring records were also held on file. In addition, the support plan contained a mouth care action plan from the dental hygienist, and a set of detailed instructions for staff about the person's passive range of movements; including photographs showing staff how to support the person to prevent their joints getting stiff and to ensure that staff were aware, when washing and dressing for instance, what range of movements the person had. We saw other examples where healthcare support plans incorporated advice and guidance from relevant healthcare professionals to ensure staff were providing care and support based on up-to-date knowledge and professional guidance.

We saw that diaries kept in the support living services included information about healthcare appointments. Records showed people were visited by, or supported to visit, healthcare professionals where necessary and that staff responded effectively to concerns about people's health and wellbeing. People we spoke with confirmed staff supported them to attend appointments, and one relative we spoke with told us, "At the moment [Name] has a health issue…They [staff] have this well sorted. They got them to the GP and have taken them to the hospital and their appointments to get it sorted."

Good

Is the service caring?

Our findings

We spoke with people using the service about whether staff were caring; the feedback we received was positive. People told us, "They [staff] are caring; I feel comfortable with them. Staff are never rude" and "They are kind and caring." Another told us, "The way they speak to you shows staff are caring." One person told us, "They do [treat you with kindness and respect]. Some are better than others, but yes they do."

All the visitors we spoke with told us that they felt that staff cared about their relative or friend. Visitors told us, "They [staff] are very positive people. They treat [Name] well and treat them with respect." One visitor told us the staff "Definitely" cared about their relative and said, "They are all so lovely; they are brilliant staff. They go the extra mile for everyone there. For instance, when they got a new piece of equipment for [Name] which enabled them to have more baths, the staff were all so excited for [Name], so you can tell how much they care." They continued, "They always treat people with respect. It's the little things that show this. For instance, when staff come on shift the first thing they do is go and say hello to each person living there, and likewise, say goodbye when they leave." Another told us they could tell how much staff cared for their relative by "The way that they talk to them and by the way that they are with them."

We observed staff supporting people throughout our inspection, and interactions were positive, friendly and respectful. We observed people using the service responded warmly to staff, and saw many examples of people laughing with staff, showing us that they had developed positive relationships with them. Throughout our inspection we saw staff displayed a caring attitude in the way they interacted both verbally and non-verbally with people using the service.

During our discussions with staff, they demonstrated a caring approach towards the people they supported and were knowledgeable about people's needs and preferences. Staff told us, "You're supposed to remain detached, but it's difficult because we are very close to people" and "We chat to people whilst supporting them; you build a close relationship with them."

We observed staff offering choices and being attentive to people's needs. Staff were able to describe how they encouraged people to make decisions and choices. This included giving us examples of smaller day to day choices, such as whether people wanted white bread or brown bread, or what they wanted to wear. One member of staff told us, "We offer choice by discussing things and offering options. We discuss the implications of each choice so that people can make an informed decision." Another member of staff told us about how they worked with people who do not communicate verbally to understand their preferences and choices; they told us about the non-verbal ways particular people they supported were able to indicate their choices. One person who used the service told us, "I like to get my own clothes out and I choose what to wear. I also choose what I do in the daytime."

Most people told us that staff listened to them and involved them in decisions. One person told us, "They ask you if things are alright, and tell you about things going on."

Evidence from support plans and discussion with staff showed us staff promoted people's independence

wherever possible. We saw that where people using the service were able to, they were involved in household tasks; we saw people washing and drying the pots, preparing drinks and food. We also saw in care files that there were instructions to staff on how to engage people with limited mobility and co-ordination in tasks like washing themselves and dusting for instance, by using hand over hand support. The environment was adapted, where required, to support people's independent living skills; in one supported living service we visited there was an adjustable height sink for instance, which was accessible to people who used wheelchairs. People using the service told us, "They encourage me to do things for myself, like getting dressed and doing the pots," "Sometimes I do jobs like dusting" and "I can make my own coffee."

We discussed with staff whether there were any people using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to their disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. Care files contained details of any cultural and religious support people required and a staff member told us they were making arrangements for one person they supported to meet up with their friends from church on a regular basis.

We discussed with people whether staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing. Comments from people were generally positive and included, "They [staff] always knock on the door first before coming in. They help me to wash on a morning and shower on a night." Staff we spoke with gave examples of how they maintained people's privacy and dignity. This included keeping people covered when washing them, ensuring the door was closed when providing care, and ensuring people had a dressing gown on when transferring from the bathroom to their bedroom, double bagging female personal items when shopping and giving people privacy when they had visitors. Throughout our inspection we saw staff always knocked on people's bedroom doors before entering and were discreet when exchanging information about people.

All the visitors we spoke with told us they were able to visit at any time and were made to feel very welcome. One told us, "As soon as I go staff are welcoming." Nobody using the supported living services we visited had an advocate at the time of our inspection, but staff told us they had shared leaflets about advocacy with people and that they would support people to get an advocate if anyone wanted one. Most people had some involvement from families, or where people didn't have any family staff were building a 'circle of support' for people; including friends and contacts who could help that person express their views and wishes.

We observed staff supporting people with a range of communication needs and saw they were familiar and adept at using people's preferred means of communication, and they took account of people's visual impairment. Support plans contained detailed information about people's means of communication, including non-verbal gestures, expressions and body language.

Good

Is the service responsive?

Our findings

People using the service all had a support plan, and there was evidence that people had been involved in developing these, where they had the capacity to do so. We saw support plans contained personalised information about people's needs, incorporating details about people's particular likes and dislikes about how those needs should be met. Staff told us they spent time reading the support plans, so that they understood people's preferences. This showed staff had the information they needed to provide support to people.

Support plans included detailed information about how to support people with daily opportunities, healthcare needs, communication and any physical interventions. They also contained information about people's goals and aspirations and about their weekly routines. The files were produced in a partly pictorial format. People had additional files in relation to their medication and health needs and their finances. There was also a daily file for each individual which contained handover records in relation to that person, daily recording logs and monthly appointment sheets, showing any healthcare or personal appointments, trips and birthdays that month. The file also contained a record of the one to one support hours provided each week.

Support plans were reviewed and updated where required, but we found some inconsistencies in how staff were recording when the support plan had been reviewed. It was difficult, in some cases, to clearly track what changes had been made, and when these had been implemented. The registered manager issued a note to group leaders on the first day of our inspection about this, with instruction about a consistent way to do this.

Support plans were lengthy and there was some duplication of information in people's files. A number of staff told us they were aware that the organisation was currently looking at ways to improve the format of support plans, so they were easier and clearer to use, and staff said they felt this would be beneficial.

Discussion with staff showed us that they were knowledgeable about people's needs and one person using the service told us, "Staff know what I like!" When we talked with visitors about whether they felt staff understood their relative's needs and preferences, and provided them with personalised care, their comments included, "Yes, without a doubt; they know all the things [Name] likes" and "Yes, [Name] makes it known if not! They know [Name] well."

People using the service told us they were able to do the things they liked and were supported to take part in activities and access their wider community. One person we spoke with told us, using signs and support from staff, that they enjoyed going shopping, aromatherapy, having their nails painted, craft work and going out on the bus. Another person told us they had recently been on a weekend away with a member of staff. One person told us that they felt their mobility needs impacted on their ability to go out as much as they would like, but said they did go to the pub sometimes.

Visitors told us, "[Name] has volunteers coming in, so they can do things with them. They also have some

one to one support hours each week so [Name] can choose what to do with staff at those times too." Other visitors told us, "I go to parties at the home. Staff also take her out about twice a week; she goes shopping with them and so on" and "[Name] goes on courses sometimes, such as cooking and baking. There are plenty of opportunities, but [Name] doesn't always want to do them

People we spoke with told us they would feel comfortable raising any concerns with the managers at The Wilberforce Trust, and they felt confident that any issues they raised would be addressed. The registered provider had a policy and procedure in place outlining how they managed and responded to complaints. We looked at records held in relation to complaints. One complaint had arisen because a relative felt the service had not responded in a timely way to their request for some information they required. Another involved a safeguarding issue, and this had been appropriately addressed and responded to. We looked at compliments received; these included compliments from visiting healthcare professionals and families. Visitors we spoke with told us, "I would definitely feel comfortable raising any concerns" and "[If I had a complaint or concern] I would raise it with [group manager] and feel confident that they would sort out the problem."

We saw from minutes of tenant's meetings and support plans, that people had opportunity to share their views about their care and issues at their home, and that the registered provider was acting on this information. In one of the supported living services we visited they did not hold tenant's meetings, because a group meeting format was not appropriate to the needs of people living there, so staff told us how they used observations of people's responses to events and activities, in order to gain feedback from people. The registered provider also worked with a partner organisation to produce a quarterly newsletter for people; this was produced in braille and audio format. There was a regular tenant's forum; the minutes of which were produced in audio format.

Requires Improvement

Is the service well-led?

Our findings

This location is required to have a registered manager as a condition of registration. There was a registered manager in post at the time of our inspection and they had been in post since 2014.

Since our last inspection the organisation had gone through a period of significant change and there had been a management and staffing restructure in late 2015. Following this the registered manager had been supported by a senior group leader and three group leaders, who each had responsibility for three supported living services. Some support staff also had additional responsibilities as champions in particular areas, such as health and safety.

The registered provider advised us that as part of the organisational change there had been a focus over the previous year on standardising practice across all the supported living locations, so that the quality of care, along with the systems and paperwork, were consistent. This enabled staff to be able to work flexibly across more than one location when required. Each department of the organisation had produced an action plan with their key priorities for improvement and development.

A number of staff told us that the process of change had been very difficult but the new structure was now embedding and they were feeling more settled in their roles and expectations. This included getting used to group leaders being present in the homes less, due to having responsibility for three supported living services since the restructure. Comments from staff included, "We've ridden the storm and we're getting there now. It feels more together and we're integrating a lot more across all nine services" and "We're getting there now, there have been lots of small steps and now we're receptive to improvements in how we work. We each have an extra job to do… we're still learning how to do certain things but staff are getting more confident about dealing with things in the absence of a manager now." Other comments included, "We've had a lot of improvements over time, in terms of the vision and transparency, and communication is a lot better." Another staff member told us, "I don't see a massive amount of [group leader] but I can always pick up the phone and they give me everything I need. I get an immediate response. The rest of the team have also all been brilliant and really supportive."

When we spoke with visitors about the management and leadership of the service, comments included, "Generally it is good; they are great and I have no complaints whatsoever. I didn't think the new system of having one manager for three homes was going to work, but it seems to be fine. [Group leader] has given me their number, so even if they're not there when I visit I can always ring them if I have a problem." A visitor to one of the supported living services we visited commented on the number of management changes there had been at that service, but told us that, "All the managers have been fine, and the changes in management haven't affected the consistency of [Name]'s care."

The registered manager told us they kept up to date with best practice and legislation by subscribing to Skills for Care email bulletins, by attending a solicitor's seminar and receiving their email bulletins. They also attended various events and conferences, including events specialising in support to people with visual impairments.

People using the service told us "I like living here" and "Everything is going very well as far as I'm concerned" and "Everything is as I would like it. I can't think of anything I would change." We observed other people using the service to be content and at ease in their surroundings indicating they were happy with the care and support provided.

Staff and visitors also commented on the positive culture of the organisation. Visitors told us, "Staff respect each other; you can see that. They always communicate with each other and get on well, so you can tell there is a positive culture" and "There is a good atmosphere." Another told us, "I'm highly delighted, [Name] is highly delighted and we both think the staff are marvellous." Comments from staff included, "I really like this service, it's really nice to work in. The tenants come across as happy and the team are really supportive. We're a good team and this is good for tenants too obviously. [Group manager] is good at making sure things are person centred."

Whilst the feedback we received about the organisational changes was generally positive, it was evident during the inspection that some of the new systems were yet to be fully imbedded. We found examples of inconsistency in how information was recorded and staff were not always able to quickly locate information we requested due to changes in where records were being stored, such as information about staffing and supervision records. Not all staff had received supervision from their line manager in the last three months, but plans were in place to address this and staff told us that they felt supported. We saw evidence of staff forums and team meetings.

Although the feedback we received about the quality of the service indicated a good level of satisfaction about the service provided, the registered provider's quality assurance systems were not sufficiently robust.

We were told there had been a care compliance officer in post until about two months prior to our inspection, and that they completed quality assurance compliance visits to the supported living services. When we asked to view copies of these compliance visits staff were only able to locate the records of one compliance visit to a supported living service, and this document was not dated, so it was not possible to determine when it had been conducted. Group leaders told us that other compliance visits had taken place but records of these visits could not be located, so it was not possible to evidence that they were being regularly conducted across all services or that they were being used to improve practice. The registered manager told us, and staff and people using the service confirmed, that the registered manager visited the services to observe practice and talk to people about their experiences. Group managers told us that the registered manager provided written feedback from these observation visits, but only two records of these visits could be located.

Two visitors we spoke with told us they were not aware of any formal feedback systems to gather their views, such as relative's meetings or surveys. There was however, a family representative on the registered provider's board of trustees.

Regular health and safety checks were conducted in supported living services, but we found that in one service there were gaps in these weekly checks when the service had been without a manager for approximately a month, which showed that contingency arrangements were not in place to ensure all checks were completed in the absence a manager. We also found an example of a health and safety audit that was incorrectly completed. Other than health and safety checks, there was limited evidence of other audits completed in the supported living services. Lots of records were kept in relation to individuals and care delivery but it was not clear how these records were audited or used to help monitor the quality of the service. Group managers told us they conducted spot checks on medication and people's finances each week, but these checks were not recorded. In response to our feedback, after the first day of our inspection

the registered manager responded promptly by producing an audit tool to record these medication and finance checks, along with audits in relation to nutrition, support plans and other care documentation.

Accidents, incidents and issues from the on-call system were recorded in a paper copy folder and an electronic log. Information from this electronic log was used to contribute towards the production a quarterly care compliance report for the care compliance committee. This committee reported to the board of trustees for the organisation, so the report was used by senior managers and trustees to monitor issues and trends. We found that accident and incident forms were not always checked and signed by the care compliance officer, as required on the form, and where forms had been signed by a manager to confirm that appropriate responsive action had been taken, there was no space to identify the name of the person completing the form, so it was not possible to identify which manager had completed it. We also found an example of an incident recorded in the hard copy accidents and incidents file that had not been added to the electronic log, so the manager of the service involved was not aware of the incident. It was discovered on one day of our inspection that there were two different versions of the electronic log in use, and some managers had been logging required updates on the wrong version in error. This was corrected on the day of our inspection, to ensure there was only one version running. Examples like this showed us that the accident and incident log was not always being used effectively and could therefore not always be relied upon to produce accurate data for the quarterly care compliance report.

We concluded that quality assurance processes were not sufficiently robust, and this was a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider's quality assurance processes were not sufficiently robust to assess, monitor and improve the quality of the services provided, or assess monitor and mitigate the risks relating to the health, safety and welfare of service users.