Walsingham Support

Walsingham Support - Supported Living West Cumbria

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Walsingham Support- Supported Living West Cumbria is a domiciliary care service, providing personal care to people who may live with physical disability, mental health needs, learning disabilities or autistic spectrum disorder living in their own homes. The service supported people living across 26 houses in West and North Cumbria. Some people lived in their own houses. Other people lived in shared houses, where they had their own bedrooms and shared facilities such as communal areas, bathrooms and kitchens.

Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the service supported 56 people with personal care.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities, that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
Whilst people felt safe with the staff supporting them, we found further work was needed to ensure safeguarding concerns were identified by staff, raised appropriately and shared with relevant organisations. We have made a recommendation about this.

People had busy diaries of fulfilling and meaningful actives. This included working in charities in their local communities, pursuing chosen hobbies and taking part in sporting activities. People eagerly spoke of their achievements and were proud of these.

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

Right Care:
Staff were kind and compassionate. Support staff treated people with dignity and respect. People were supported in a person-centred way that reflected their individual choices and enjoyed positive and meaningful interactions with staff.

Right Culture:
The provider did not always have effective systems and processes in place to support the delivery of high-

quality care. Issues with the provider's IT systems meant full, accurate and up to date information about people's care needs was not always recorded in one place. This put people at risk of harm.

People were supported by skilled staff whose values, attitudes and behaviours empowered people to achieve their goals. Staff encouraged teamwork between people and a sense of empowerment to take individual and collective decisions in relation to their home surroundings.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 29 May 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We carried out an unannounced focused inspection on 21 June 2023. We inspected the Safe and Well-led key questions. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service is requires improvement, based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led key section of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Walsingham Support- Supported Living Services West Cumbria on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified a breach in relation to good governance at this the service. Please see the action we have told the provider to take at the end of this report.

We have made a recommendation about safeguarding and CQC notifications.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Walsingham Support - Supported Living West Cumbria

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 2 inspectors and 1 regulatory co-ordinator, who is a member of CQC operational support services.

Service and service type
Walsingham Support- Supported Living West Cumbria is a `domiciliary care service` which provides care and support to people living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. This means that they and the provider are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the first day of inspection.

Inspection activity started on 21 June and ended on 11 July 2023. We visited the location's office on 21 June.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information gathered as part of a CQC monitoring activity. We sought feedback from the local authorities and professionals that work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited 5 houses and observed how staff interacted with people. We spoke with 7 people who used the service and 9 relatives about their experiences of the care provided.

We spoke with 17 staff including the nominated individual, regional manager, registered manager, scheme managers and support staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included people's care records and medicine records and 5 staff recruitment files. A variety of records relating to the management of the service, including action plans, policies and procedures were also reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
- Systems were not always established or followed to ensure a consistent approach to safeguarding people.
- Although staff had received safeguarding training, staff did not always recognise when abuse or neglect may have occurred and follow required processes. For example, staff did not always consider known risks to people in order to decide if a safeguarding referral was needed. This was brought to the attention of the provider, who acted immediately.
- We were not assured abuse or allegations of abuse were consistently reported to CQC. Safeguarding concerns were initially reported to the local authority and CQC were only notified if they were substantiated. We discussed this with the registered manager who agreed all future safeguarding concerns would be reported to the CQC at the time the concern was identified.

We recommend the provider reviews safeguarding best practice guidance and CQC guidance on notifications.

- People we spoke with told us they felt safe.

Assessing risk, safety monitoring and management
- Risks to people were not always managed or recorded consistently.
- Issues with the provider's IT systems meant up to date information about risks to people was not always recorded in one place and accessible to all staff.
- Staff were involved in updating risk assessments. One staff member said, "I updated [Name of person's] risk assessment yesterday as there was a change affecting their eating".
- Relatives had mixed views about staff's understanding of the risks to people.

Using medicines safely
- Medicines were managed safely and properly overall.
- People received appropriate support to manage and administer their medicines. People were encouraged to be independent with their medicines administration where possible.
- Staff told us they had been trained in supporting people with their medication and records seen confirmed this.

Learning lessons when things go wrong
- Records showed accidents and incidents were investigated and lessons learned tracked via action plans.

● Systems to ensure all appropriate actions were taken following safeguarding concerns and medicines errors were still being embedded.

Staffing and recruitment
● People were supported by staff that were safely recruited and had the right skills to support them.
● Staff recruitment processes followed the providers recruitment policy. Records showed checks were conducted as part of the recruitment process, to ensure staff were suitable to support people in their homes. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● People using the service were involved in the recruitment processes including sitting on interview panels. We saw one person at the office, who was available to help with the service's recruitment drop-in day.
●Staff told us they received induction training and specific training to meet people's individual needs and records we saw confirmed this.
●Staff skills matched the needs of the people using the service. We observed this and people using the service told us they liked the staff who were supporting them. A relative said, "the people who are helping [Name of person] are absolutely brilliant, it helps them to be independent of us, which is good for them." Staff told us they had received a range of training relating to people's needs and records confirmed this.

Preventing and controlling infection
● Staff supported people to clean their own rooms and communal areas.
● Each house had supplies of hand cleaning products in the kitchen and bathroom.
● People were proud of their homes; at one location a person took the inspector round the home to introduce the people living there and the staff supporting them. This person was able to tell the inspector who was responsible for cleaning the communal areas and how they made sure it did not impact on any of their plans or appointments.

Ensuring consent to care and treatment in line with law and guidance
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. 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● People were supported in person-centred ways and encouraged to make decisions for themselves where possible.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question as good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to ensure governance and managerial oversight were effective at monitoring the quality and safety of the service.
- People's safety was at risk due to shortfalls with the provider's IT systems. The provider was not always aware of all issues affecting staff access to the provider's computer systems, containing people's care plans and risk assessments. The provider took action to rectify the position but failed to identify the potential impact of this on people's safety.
- IT issues across the service meant staff could not always view, review or update care plans and risk assessments. Staff told us this issue had been ongoing and intermittent and to address this, staff made notes to put on the system later.
- The provider had failed to identify the issues we found on inspection with safeguarding, notifications, care records and risk assessments and action plans.

We found no evidence that people had been harmed. The provider's systems and processes were not robust enough to demonstrate quality and safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and manager were new to post and meeting people using the services and the support workers providing it.
- Staff felt supported by scheme managers and told us they had regular opportunities to meet with them to discuss the service and their views. One support worker said, "We have supervision meetings every 6-8 weeks, however I would not wait for the next supervision would just speak to the manager if it was needed".
- Staff had received training in the needs of the people they supported and had access to ongoing remote training to ensure their skills remained relevant to people they were supporting.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider was committed to providing person-centred care.
- People's relatives had mixed views about the culture and the way the service was run. One relative told us, "They are changing all the time, there's always someone different and so many managers leaving". Another relative told us, "The service they provide is absolutely amazing, any little thing, they phone me up to ask my

permission, advice or check or inform me. I'm fully informed. Any issues I've raised are addressed immediately".
● People told us they got on well with the scheme managers and other people they lived with. We saw evidence of this during our visits to people's homes.
● Staff were committed to providing people with high standards of care, tailored to their needs and preferences. One staff member told us, "I enjoy being with [name of person] and taking them out".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their duty of candour and was open and honest about where the service needed to improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Feedback on the provider's engagement at the service was mixed. Some staff told us they did not feel confident to raise issues about the service.
● The provider was making changes to the management structure of the service. Some staff we spoke with felt disconnected from the management changes or were not aware of them. One staff member told us, "I don't know what the changes are, but staff and people are not affected". Other staff stated, "Information received is either inaccurate or wrong, it`s confusing" and "The new manager is making an effort to meet us all, came out to the service and invited us to the new office".
● Managers informed us meetings were taking place to explain changes, to staff. However, the staff we spoke with were either not aware of these meetings or had not attended.
● People were consulted with and involved in the organising of their home environments. Two people explained to inspectors about their weekly house meetings how they decided and agreed amongst themselves what each person's contribution would be, towards keeping communal areas tidy, clean and fresh.
● Relatives told us the service regularly engaged with them. Relative told us, "The manager has been in contact a lot and recently", and "they do involve me, the manager is absolutely brilliant, there are plans for a new manager, the general manager is dealing with things until then".

Working in partnership with others
● The provider was working to establish and develop relationships with other services and external stakeholders.
● The new management team were establishing their contacts with people using the service and their relatives, as well as local community health and social care professionals, local authority departments and services within the community, to ensure people were effectively supported.

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 provider had failed to have established and effective systems and processes in place to assess, monitor and improve the quality and safety of the service. The provider had failed to assess, monitor and mitigate risks to service users and maintain accurate, complete and up to date records for service users. (1)(2)(a)(b)(c)