Care Quality Commission

Select Support Partnerships Ltd

Oldham

Inspection report

Malcolm House, 27 Windsor Road
Newton Heath
Manchester
Lancashire
M40 1QQ

Tel: 01612586039
Website: www.selectsupportpartnerships.com

Date of inspection visit:
20 February 2018
21 February 2018

Date of publication:
19 March 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 service is located on the outskirts of Oldham in Newton Heath. The service are registered to provide personal care in people's own homes called domiciliary care and also supported living services to people who have Autism or a learning disability. There were three people using the supported living service and nobody currently using the domiciliary care service. One of the people using the supported living service was in hospital.

This was the first rated inspection for the service. This inspection was conducted on the 20 and 21 February 2018 and was announced in line with our guidance to ensure staff were present at the service.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October 2014. However, there was a person appointed at the service who had sent in an application to be registered and was to be interviewed on the 07 March 2018.

We made a recommendation that staff look at best practice guidelines for obtaining the last wishes of people who used the service.

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

Risk assessments for health needs or environmental hazards helped protect the health and welfare of people who used the service but did not restrict their lifestyles.

Staff were trained in the administration of medicines and managers checked the records to help spot any errors and keep people safe.

Staff were trained in infection control topics and issued with personal protective equipment to help prevent the spread of infection.

Staff received an induction and were supported when they commenced employment to become competent to work with vulnerable people. Staff were well trained and supervised to feel confident within their roles. Staff were encouraged to take further training in health and social care topics.

People were supported to take a healthy diet if required and staff were trained in nutrition and food safety.

The service were of aware of how to protect a person's rights by following the principles of the Mental Capacity Act.

We observed a good rapport between people who used the service and staff. People were supported by a regular staff team who knew them well.

Staff were able to use their skills to communicate with people.

Personal records were held securely to help protect people's privacy.

There was a complaints procedure for people to raise any concerns they may have.

People were assisted to attend meaningful activities.

Plans of care gave staff clear details of what care people needed. People helped develop their plans of care to ensure the care they received was what they wanted.

There were systems in place to monitor the quality of service provision and where needed the manager took action to improve the service.

The office was suitable for providing a supported living/domiciliary care service and was staffed during office hours. There was an on call service for people to contact out of normal working hours.

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 had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse. The service used the local authority safeguarding procedures to follow a local initiative.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People who used the service were supported to take a nutritious diet.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily support the people who used the service.

Is the service caring?

Good

The service was caring.

Records were maintained securely and staff were trained in confidentiality topics.

People who used the service told us staff were trustworthy, reliable and friendly.

We observed there were good interactions between staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns.

If it was part of their care package people were able to join in activities suitable to their age, gender, culture, religious beliefs and ethnicity.

Plans of care were developed with people who used the service or where necessary family members, were individualised and kept up to date.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care agency.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they felt supported and managers were approachable.

Care Quality Commission

Oldham

Detailed findings

Background to this inspection

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

This was an announced inspection and was conducted by one adult social care inspector on the 20 and 21 February 2018. This inspection was brought forward because concerns had been raised by the local authority and Healthwatch Rochdale.

We requested and received a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help with planning the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We asked the local authority and Healthwatch Oldham for any information they had about the service. They did not have any concerns.

We spoke observed the interaction between staff and two people who used the service. They were not able to communicate with us. We spoke with the manager, area manager and thee care staff members.

We looked at the care records for three people and medicines administration records for two people who used the service. We also looked at the recruitment, training and supervision records for five members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

We saw from the training records and staff files that staff had received safeguarding training. Staff had policies and procedures available to report safeguarding issues and also used the local social services department's adult abuse procedures to follow a local initiative. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told staff about the types of abuse, how to report abuse and what to do to keep people safe. The service also provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith. All the staff we spoke with were aware of their responsibilities to report any suspected abuse to help protect people who used the service. They told us, "I would report poor practice and am aware of the whistle blowing policy"; "I would take action if I saw abuse in any form" and "We are taught how to safeguard people".

The service had reported one safeguarding issue. We saw that the service had investigated the issue and taken suitable disciplinary action against the staff member involved which showed the service were committed to keeping people safe.

We looked at five staff files and found recruitment was robust. The staff files contained a criminal records check called a Disclosure and Barring Service check (DBS). This check also examined if prospective staff had at any time been regarded as unsuitable to work with vulnerable adults. The files also contained two written references, an application form (where any gaps in employment could be investigated) and proof of address and identity. The checks should ensure staff were safe to work with vulnerable people.

Prior to using the service each person had a needs assessment completed by a member of staff from the agency. The assessment covered all aspects of a person's health and social care needs and the information was used to help form the plans of care. The local social services department also provided an assessment for their clients. The assessment process ensured agency staff could meet people's needs and that people who used the service benefitted from the placement. The assessment also took account of a person's diverse needs.

People who live in supported houses are tenants and have a tenancy agreement with a landlord. Staff said any repairs were undertaken quickly. We visited two of the supported houses and saw they were well maintained and checks carried out to ensure equipment was in working order. This included a portable appliance test (PAT) to ensure electrical equipment was safe. Staff practiced and followed the procedures for emergencies such as a fire. Each person had a personal emergency evacuation plan (PEEP). This was a document which showed what needs a person had for evacuation and could be given to the fire services to help get people out of the building in an emergency.

The service had a business continuity plan which set out how the service would function for any emergency such as a fire, loss of utilities or inclement weather. The plan highlighted the numbers for key staff and other organisations to help get services up and running as soon as possible.

All accidents and incidents were recorded by staff and audited by management to see if any triggers could be spotted and reduce the incidents.

We saw one person required one staff member to care for them and the other person was looked after at all time by two staff as required in their agreement with the local authority. Staff told us they filled in for each other or they brought in regular staff from other parts of the organisation for holidays or time off. This meant there were sufficient staff to meet people's needs but staff also knew the people who used the service well. This was important for the people who used the service because they were not able to fully communicate verbally.

People who live in their own homes are generally responsible for infection prevention and control. However, due to the level of support needed by the two people we observed this meant staff had to ensure good principles of prevention and control of infection. Staff were trained in infection control topics and used protective clothing (PPE) when required. Staff were supplied with gloves and aprons. Staff had access to a copy of the National Institute of Clinical Excellence (NICE) guidelines for infection prevention and control which is considered to be best practice. The houses were clean and tidy.

We saw from looking at three plans of care that risk assessments were undertaken for aspects of a person's personal or health care needs such as behaviours that may challenge when attending appointments, non-compliance with taking medicines or smoking. We saw the risk assessments were to protect the person or others involved in their care but did not restrict their lifestyle. There were also risk assessments for going out in the community. This helped keep people safe if they were a risk using transport or how they reacted to certain situations, for example one person had a risk assessment for their dislike of dogs.

There were policies and procedures to guide staff in the safe administration of medicines. The service also had a copy of the NICE guidelines available to staff which is considered best practice information. People being looked after in their own homes can often self-administer their medicines or just require prompting. However both people we visited required staff support to take their medicines. We saw from the training records that all staff had completed training for medicines administration and had their competencies checked regularly to ensure they were administering medicines safely.

We saw from looking at the medicines administration records (MAR) that staff recorded each time a medicine was administered. The two records we looked at showed there were no gaps or omissions. One person could be resistive to taking medicines and we saw one staff member persuaded the person to take their medicines in a professional and kind way. There was a code for taking a medicine or if people had refused.

Management audited the medicines records to check for any possible errors. We saw the service took action for any medicines errors. We saw one person had received more training and supervision following an incident.

We saw 'as required' medicines records showed clearly why the medicine should be given, the amount that could be given and how much in a set period. Staff were trained for giving specific medicines such as for epilepsy.

There was a record of the temperature medicines were stored at to ensure they were within manufacturer's guidelines and remained effective.

The service was run from an office which contained sufficient equipment to provide a good service. This

included computers with email access and telephones to keep in contact with staff. Staff had a buddy system for helping ensure people and staff were safe. Staff rang the other houses at specific times to ensure the well-being and safety of staff who may work in an environment with behaviour that challenges. Staff also had access to managers and on call staff for support if required.

Good

Is the service effective?

Our findings

Staff supported people to take a good diet. We saw in one plan of care that a person could often refuse food and drink. During the visit we saw the staff member sat with the person and verbally encouraged the person to take the food on offer. Although this took some time the staff member was patient and the person eventually ate all of the breakfast.

We saw people were asked what they liked to eat and chose their own menus. Food was ordered by staff around what a person liked. Staff were trained in safe food practices. What a person ate was recorded and we saw people had access to speech and language therapists and dieticians for advice and treatment. This meant any special needs a person had was assessed and suitable care provided.

We saw people's cultural needs were assessed in relation to their dietary intake and the food provided for one person met these requirements. The other person we visited did not have any special dietary needs as such but had behavioural issues which staff were aware of and this was recorded in the plan of care. Where possible people were encouraged to help in the kitchen under supervision and following a risk assessment.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had been trained in the MCA and DoLS.

People in their own homes are not usually subject to DoLS. The people accommodated at this service lived in sheltered housing and we saw that mental capacity assessments had been held for them to decide what action needed to be taken to ensure their care was legitimate. Best interest meetings had been held to decide how best people could be cared for in the least restrictive way. Best interest meetings included, where possible, the person using the service, family members and associated professionals. The process was ongoing with further meetings planned and applications made to the relevant authorities for a DoLS to live in a supported living service. This helped protect people's rights.

During the process people who used the service had access to independent mental capacity advisors (IMCA's) who are independent professionals who act on behalf of the person to have their wishes incorporated into their care when it is possible.

We looked at five staff files initially and a further one to look at the induction process. Staff new to the care industry were enrolled on the care certificate which is considered to be best practice. We saw files which showed staff completed the certificate in a timely manner. Staff were also shown around the office to familiarise themselves with the organisation, had to sign key policies and procedures and initially were on a probationary period. During this period they were mentored by more experienced staff until they had the confidence and competence to look after the complex and vulnerable people who used the service.

Staff we spoke with told us, "We get enough training to do the job" and "We get a lot of training, including behaviours that challenge. I have enough training to do the job." The training records showed staff had completed mandatory training for moving and handling, health and safety, basic life support, safeguarding adults and children, food hygiene, infection control, medicines administration, fire safety and the MCA/DoLS. This meant staff were given sufficient training to meet the needs of the people they looked after.

We saw most staff had completed further training in a health and social care diploma or NVQ. Staff were also trained around a person's specific needs such as Autism, safe techniques for caring for people with behaviours that challenge or epilepsy. This meant staff were given the skills to meet individual needs.

Staff we spoke with told us, "We get regular supervision and appraisal. We have a chance to have our say. I have brought up things in the past and they have taken notice" and "We get regular supervision, it's around every three months and yearly appraisal. You can discuss your career and can bring up and issue and if required they keep it confidential." We saw from the staff files that staff received an appraisal, regular supervision and competency spot checks. Staff received regular support in their roles.

Each person who used the service had a health care plan which gave staff information about a person's specific condition and any treatment they required. Each person had their own GP and access to professionals such as learning disability nurses, hospital consultants, SALT's or attended regular appointments with podiatrists, opticians and dentists. Staff supported people to attend appointments and were aware of any particular needs a person may have to support them. For example there was advice if a person may react badly to strangers or certain treatments.

The office was located on the outskirts of Oldham. There was a general office and a room for private meetings. There were facilities for staff's comfort and a small kitchen for drinks and meals. The office is part of a much larger facility which is going through the registration process. There was a car park and access to a bus route for visitors.

Good

Is the service caring?

Our findings

Staff we spoke with said, "I love the job. We are always learning. I mainly look after one person, but sometimes help out at the other service. There have been a lot of changes which is difficult to work through but I enjoy my job. I would be happy to recommend the service to a family member"; I like the work. It is all right here" and "It's a good place to work. I am happy here and like looking after the person who lives here.

On the second day of the inspection we were assisted to meet the two available people who used the service. We were able to observe the interaction between staff and people who used the service and found staff to be kind, attentive and professional. We were unable to communicate with people who used the service but saw that staff knew what people wanted. Both people who used the service appeared to know what was being said and saw that staff were knowledgeable in how to communicate with them.

The plans of care we looked at had a large section on how staff could interpret what people who used the service wanted. This had been developed with Oldham Metropolitan Borough Councils learning disability service, family members and members of the services staff. The communication dictionary told us what a person may be trying to communicate by the actions they showed. For example, what a person may look like if in pain, bored, happy, sad or bored. The list was extensive. The document told staff what to try to do to help the person giving examples of the care they should try. This meant the service had assessed the person's communication needs to try to help them live a less frustrating life.

We looked at three plans of care during the inspection. Plans of care were personalised and had been developed with people who used the service so their choices were known. People's likes and dislikes were included in the plans. This helped treat people as individuals.

There was a large section in the plans of care devoted to people's choices, what was important to them, what they liked to do and where they liked to go. The plans also told staff what level of choice they could make and what they liked to choose themselves. People liked to choose their own clothes, the times and where they went out and how they liked to spend their day. People with Autism or a Learning Disability can often feel more secure in a structured life. Plans of care were also developed to show what a person's normal routine day was. People were given choices even though this could sometimes mean they lived a quite structured life.

We noted all care files and other documents were stored securely to help keep all information confidential and were only available to staff who had need to access them. Staff were taught about confidentiality and had a policy to remind them to keep people's information safe.

We saw that staff had time to sit and talk to people and waited for their response. Staff were careful to explain what it was they wanted and communicated with people who used the service in the way they were able.

People lived in their own house and during our visits one person required personal care. We saw the staff

member was careful to protect the person's privacy and encouraged the person accept the care required. This helped to protect the person's dignity.

We saw that staff used verbal and non-verbal means of communication. One person had religious needs which the service worked around and supported. A family member of this person looked after the person's religious needs. This person also required a special diet which the service were aware of and supplied the person with foods suitable to their religious and cultural needs. The service looked after people in a manner that looked after their needs in relation to their age, gender, sexuality, cultural and religion.

The service supported people who used the service to visit their family members and also to come to their own house. This ensured people were able to maintain contact with family and friends.

Good

Is the service responsive?

Our findings

We saw that there was an accessible copy of the complaints procedure within their documentation. This told people who to complain to, how to complain and the time it would take for any response. The procedure also gave people the contact details of other organisations they could take any concerns further if they wished including the Care Quality Commission (CQC) and Rochdale Metropolitan Borough Council. There had not been any concerns raised by service users or family members but we saw that there was a system for investigating and responding to any concerns raised.

During the assessment process the service discovered what people liked to do and supported them to attend activities of their choice. Each person we visited had access to transport to take them to venue's they liked. It also told us what people did not like. Activities included going out in the car, for walks, dining out, to museums and galleries and watching television. It was recorded what a person's favourite program was that they liked music. Staff had to support people in the community at all times to keep them safe.

The plans of care also told us of any behaviour's that may affect the delivery of care or disruption whilst out and about in the community. We saw that this was to enable staff to take people to where they wanted to go and ensured they were able to enjoy themselves.

Each person had a team of staff who looked after them. Staff told us they generally worked with one person and knew them well. This helped with people's continuity of care.

We saw that people were treated according to their age, gender, sexuality, culture and religious needs. One person at the service was from an ethnic minority background and we saw their needs were clearly identified. This person received a special diet and was able to practice their faith in an acceptable way.

Plans of care had been well developed and contained a lot of personal information about their person including all of their health and social care needs. We saw that the plans gave staff the information they needed to look after people as individuals. The plans were reviewed regularly to keep people's needs updated for staff. Each section had what the need was, what the goal was and a lot of detail around how staff could support them to reach the desired outcome. The plans clearly set out what staff had to do at each visit. For example, what was required in the morning, lunch time, tea time and evening. Plans of care clearly showed what level of support a person needed.

People's care was also reviewed by staff and external professionals at meetings. Family members' if relevant, were also invited to ensure people received the care they needed.

We asked the manager what plans they had for a person's end of life care or last wishes. A nurse who was present said they were developing an end of life plan but had not had time to complete it. Although people who used the service were younger adults it is good practice to have the basic details people would want in the event of an illness or accident. We have recommended the service look at best practice guidelines for producing an end of life plan to ensure people's wishes are known. We also suggested they contact the local

hospice who may have some advice to give to the service.

For the people we visited the service did not require any specific technology. Staff were issued with telephones which were used to contact the office and to keep in touch with each other when working alone. People who used the service were supported 24 hours a day by at least one member of staff.

Good

Is the service well-led?

Our findings

There was currently no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October 2014. However, there was a person appointed at the home who had sent in an application to be registered and was to be interviewed on the 07 March 2018.

We asked staff about management at the service. Staff we spoke with said. "I feel we are very well supported. The manager is very approachable and supportive. You can get hold of them if you need to. I am happy working for this organisation"; "We can get hold managers in an emergency. They are all supportive and we have a good team" and "We get enough support from management." Staff thought managers were approachable and available but also made it clear they supported each other.

We saw that staff had access to policies and procedures to help them with their practice. The policies we looked at included infection control, challenging behaviour, confidentiality, medicines administration, the emergency protocol for hospital admissions, equality, diversity and inclusion whistle blowing, mental capacity, health and safety, medicines administration and behaviours that may challenge. The policies were reviewed to keep information up to date.

Staff told us, "We have staff meetings and discuss things like people's personal care, transport and activities. We go to the office, and a manager is present. We are allowed to say our piece or bring up any grievances but mostly it's about the care of the people who use the service" and "We have lots of meetings and can bring up topics we want or training needs." We saw records of house meetings and at the last meeting of 12/12/2017 items on the agenda included a reminder to complete and read necessary paperwork, shopping, the new accident and incident recording system, archiving documents and checking food left in the fridge. Staff were able to have their say in how the service was run.

Managers and the area manager conducted audits to check the quality of the service given. Audits included checks on people's houses to ensure they were clean and safe, health and safety, medicines administration, training and supervision, staffing arrangements, safeguarding incidents, complaints and compliments, new developments and finances. The audits helped management maintain and improve the service. We saw from the audits that some service within the organisation had been improved, for example houses had been upgraded.

During the house audits we saw managers looked at the quality of the support plans, activity plan, risk assessments, health action plan, daily diary sheets, medicines, finances, accident reporting and the environment. The audit told us what was found and what action needed to be taken by which staff member. Following audits we saw advice was given to update a risk assessment, the finance support plan was updated and training was given around best interest paperwork. This showed the service were proactive in maintaining and improving care and support.

We saw the service liaised well with other organisations which included the DoLS team, the mental health team, specialist nurses, local authority commissioners of services and the housing associations people used for their homes.

The service used the National Institute of Clinical Excellence (NICE) guidelines for infection control, medicines administration and supported living. This guidance is considered to be best practice guidance and showed the service used research to provide their service. There was also a statement of purpose and service user guide which gave people, family members and external professionals information about the service to show what the service provided.