Look Ahead Care and Support Limited

Bracknell Supported Living Service

Inspection report

1 Rainforest Walk
Bracknell
Berkshire
RG12 7GB

Tel: 01344868330
Website: www.lookahead.org.uk

Date of inspection visit:
17 May 2018
23 May 2018

Date of publication:
20 August 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

This inspection took place on 17 and 23 May 2018, and was announced. Bracknell Supported Living Service is a supported living service (SLS). SLS provides support and personal care to people within shared accommodation where people hold individual tenancies and share the support with specific hours of support added as required. This may include specific hours to help promote a person's independence, assistance with personal care and well-being. Not everyone using Bracknell Supported Living Services receives regulated activity; Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. The service provided support to younger adults who had a diagnosis of learning disabilities or associated needs, with a varying level of personal care needs. At the time of the inspection two people using the service received the regulated activity of personal care, whilst other people received social and leisure support.

This was the first inspection completed for the service that registered with CQC in May 2017. The service had newly appointed a manager who was due to commence the process of registration with the 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.

The service had previously been managed by two registered managers who had both left the organisation within the last 12 months. A third manager commenced the registration process, however withdrew their application. The current manager was appointed thereafter. The services had therefore not had consistent managerial overview of operations. The service employed three part time staff, one newly recruited staff and four bank workers. The management of the service consisted of a newly appointed manager, the service manager and a consultant.

The management of the service had been inconsistent over the last 12 months. This had led to overall issues with service performance and management.

The service was not always safe. The service had not ensured that all staff employed had been through a robust recruitment process. During this inspection we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not follow their recruitment procedure to carry out checks before new staff were employed to work with people. They did not gather necessary information to ensure staff were suitable for their role. You can see what action we have asked the provider to take at the end of the full version of this report.

Risks were appropriately assessed with details provided on how to mitigate risks where possible. These focused on people retaining their independence as far as possible such as outings, excursions with the family and accessing the internet.

Medicines were generally managed safely. Audits indicated that there had been no recent medicine errors. However, the paperwork did not clearly illustrate if staff had been appropriately assessed as competent prior to administering medicines. The service reassured us that all staff would be assessed prior to completing this task moving forward.

Staff were aware of signs of abuse and how to safeguard people from abuse. The service also spoke with people and taught them to understand how they should keep themselves safe.

Care plans were person centred and very detailed. They provided comprehensive step by step guidance to staff on how people needed to be supported. Reviews took place as required and involved people and their families.

The service worked effectively with external agencies and families in ensuring people received the best support possible.

Staff were described as caring, and as maintaining people's privacy and dignity. Staff spoke with people in a caring manner, helping them make choices for themselves. People were encouraged to maintain their independence and where possible measures were taken to assist with this.

A comprehensive complaints system was in place that ensured an appropriate response to poor practice was taken in line with legislation. Concerns were thoroughly investigated and responses provided to complainants in line with company policy.

Audits were in place and new action plans had been developed to focus on the path the new manager wished to take with the service. Staff were appropriately supported and supervised to ensure they felt involved in the vision of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Robust recruitment procedures had not been implemented to ensure staff were safe to carry out their duties.

Medicines were not always managed consistently Whilst staff were provided with relevant training, it was unclear if they had been appropriately assessed as competent prior to supporting people.

Risks were assessed and appropriate measures taken to mitigate risk where possible.

Incidents were appropriately recorded and assessed.

Staff had a comprehensive understanding of the safeguarding policy and what actions to take if they suspected abuse.

Is the service effective?

Good

The service was effective.

The new staff team were appropriately supervised and supported to effectively carry out their duties.

Staff received a comprehensive induction and a thorough training programme that had been developed in conjunction with an accredited training provider.

Families and people had been involved in the recruitment process of new staff, The involvement allowed effective delivery of care and working in partnership with the client group.

The staff had a comprehensive understanding of the Mental Capacity Act and its principles. They were able to put these into action in practice.

Is the service caring?

Good

The service was caring.

Staff ensured they maintained people's dignity and respect when working with them.

Staff met people's diverse needs.

People were supported to maintain their independence and privacy at all times.

Records were maintained safely and securely.

Is the service responsive?

Good

The service was responsive.

A complaints procedure was in place. Complaints were investigated and managed appropriately.

Care plans were person centred and comprehensive.

Reviews took place and involved people and their relatives.

The service communicated with people in the way that they chose. Where required documents were prepared in an easy to read or pictorial format.

Is the service well-led?

Requires Improvement

The service was not always well-led

The service had inconsistent management over the last 12 months

The service completed audits, and developed action plans from these.

A business contingency plan was in place to consider all eventualities.

Bracknell Supported Living Service

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 inspection took place on 17 and 23 May 2018 and was announced. The inspection was completed by one inspector over both days. We gave the service 48 hours' notice of the inspection visit because the service is a supported living service that offers the regulated activity of personal care. We needed to be sure that someone would be available to give us access to documentation that we may require viewing for the purpose of the inspection.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We were unable to refer to previous inspection reports as this was the service's first inspection since being registered. We did check notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service. As part of the inspection process we also look at the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, the service had gone through several changes at management level and it was unclear if the PIR had been received. We were unable to locate one from the records held by the CQC.

During the inspection we spoke with five members of staff, including two care support workers, the manager, the service manager and a consultant who was working as part of the management team. We spoke with two relatives of people who use the service and two professionals. We were unable to speak with people who use the service due to them being unavailable on both dates of the inspection.

Care Plans, health records, additional documentation relevant to support mechanisms were seen for two

people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for six of the regular staff team were looked at.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. The recruitment process was not robust and we identified areas where the service had failed to obtain the relevant pre-employment information to ensure people were kept safe. For example of the six records we looked at, two did not have a complete employment history and did not explain gaps in employment. One file did not contain an application form. One file did not keep any photographic evidence of staff ID. None of the files contained up to date photos of staff. We noted that the provider's own recruitment policy was not met with the current employment files. None of the files contained confirmation that staff were fit, healthy and able to carry out their duties safely. All files contained references for staff in relation to their conduct in previous employment and a Disclosure and Barring Service check (DBS). A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. A safe recruitment process had not been implemented by the management to ensure staff were able to carry out their duties both safely and effectively. As such people were not protected from the potential of harm.

This was a breach of regulation of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. which identifies the need for the registered person to ensure all staff employed are safe to carry out their duties in line with Schedule 3.

People were not supported by a strong and consistent staff team. There were significant changes of staff and management teams. This meant that people did not know the staff well, and this in turn had not allowed relationships to develop. However, relatives told us that people felt safe with the current visiting staff. A person reported to the management that they were feeling highly vulnerable when two staff worked with them in their home, following staff whistle-blowing on poor practice. The service had taken the appropriate action and commenced disciplinary proceedings.

The service ensured that people were kept safe by staff who had a comprehensive understanding of safeguarding and whistleblowing procedures. They were able to describe the various types and signs of potential abuse. Training records showed staff had undertaken training in safeguarding people against abuse. Staff were aware of external agencies that should be contacted in circumstances where the staff thought that either the manager or the organisation were involved in the abuse. For example, the police, local authority, safeguarding team or the CQC were identified as possible agencies to contact. We spoke with staff about whistle-blowing and their understanding of this policy. The staff we spoke with were clear in that they would not hesitate in whistle-blowing if this was required. We saw evidence of whistleblowing having being dealt with appropriately within the service, where concerns had been raised. The service had taken immediate action and notified the appropriate authorities.

People were also made aware of what "keeping safe" meant. Discussions were held during house meetings on this topic. People were also provided with a handbook that contained information in an easy to read and pictorial format, on who to call. This was given to them to retain in their home. Families told us that they were aware of the contact details and would encourage their relatives to make contact as required if they did not feel safe.

People had their risks assessed to ensure they were kept safe whilst being able to retain their independence. Staff assessed and documented how to manage these within risk assessments and care plans. For example, one person who wished to access the community but had little road awareness, had a specific plan written to enable them to do so safely.

In accordance with the service medicine management policy all staff involved in administering medicines needed to receive training, have read the policy and be assessed as competent prior to being allowed to administer medicines. However, records indicated that two staff had been signed off as ready to administer medicines, when they had according to this document not completed training, read the policy or been assessed as competent. These staff were involved in administering medicines. The management team were unaware of this error. They had not been involved in signing off the staff. They could not advise if this was an error on part of the assessor, or if the staff had not completed any of the relevant tasks required prior to sign off. We raised this as a concern, and we were reassured that staff would be taken off administering medicines immediately. The service had completed monthly audits on medicines. These did not indicate any errors had occurred as a result of this. The impact of this error on people although had the potential of being severe, had been minimal. We received confirmation from other staff that they had been assessed competent and received the relevant training prior to administering medicines.

Records of 'as required' (PRN) medicines illustrated that staff were given sufficient information on when these needed to be administered. This is a document that gives guidance to staff on what action to take prior to offering a person PRN medicines, as well as illustrating possible signs that PRN needs to be given. Guidelines are written to ensure that medicines are only given when necessary, and not used as a means of controlling a person or behaviours.

A system was in place to monitor incidents and accidents. This allowed the manager to assess an increase in incidents or accidents, which would then prompt them to complete the necessary trends analysis. This analysis would look at how to manage the incidents and accidents, minimising the frequency and severity. Where necessary the relevant authorities would be contacted or alerted.

A business contingency plan was in place that focused on what action needed to be taken if the service needed to stop functioning for any untoward reasons. Examples included adverse weather conditions as well as staff shortage due to illness. Emergency contact numbers were included within the contingency plan, as well as what staff should do if they were unable to complete calls and shifts.

Staff were provided with personal protective equipment (PPE), to prevent the possible spread of infection. Disposable gloves and aprons were retained in the homes for staff to use when helping people with personal care. In addition when assisting people with food preparation, different food boards were used to prevent cross contamination.

Good

Is the service effective?

Our findings

People's needs and choices were assessed prior to them commencing the service and then continually following admission. An initial assessment document was completed that detailed how the person wished to be cared for and supported to maintain their independence, and where assistance was required. The person and, where relevant, relatives or professionals provided further information on how the person may be best supported. This information was used to formulate a personalised care plan that would be reviewed and updated as required.

The service had implemented an equality diversity and human rights (EDHR) policy. This specifically looked at what measures the service would employ to keep people protected regardless of their sexuality, disability, gender preference and religion. As part of the initial assessment questions around these areas were discussed. People's protected characteristics were appropriately safely and securely managed, in line with their wishes and the legislation. We saw evidence of people's physical needs not impinging on their ability to partake in activities. The service helped arranged and supported where required people to engage in meaningful tasks that added value to their life. For example, people were supported to access day services, go on day excursions and into the local community for lunch.

People were cared for by a team of staff who underwent an induction process. This included completion of mandatory training and additional training that would be supportive to them in their role. The training matrix showed that all training for staff within the service was either up to date or booked. We found that one newly recruited member of staff had commenced support without having completed all mandatory training... However, they had previously worked in social care, therefore had the necessary experience to support people whilst awaiting the training. The service was also working with an accredited training company in developing specific training for staff and for people to help them remain safe. For example, pictorial books had been developed titled "Travelling on public transport" and "Money management". These focused on helping the person develop skills to effectively increase independence whilst supported by staff. We were unable to check the progress as the service had only just commenced this.

People were supported by a staff team that received monthly supervision. This provided both the staff and the manager the opportunity to discuss their job role in relation to areas that needed support or improvement, as well as areas where they excel. One member of staff told us, "This is very useful, we have an opportunity to iron out issues, and make the experience better for the people we support." This is an example of how supervisions were used to improve both personal practice and the support people received.

People were supported to maintain a healthy and balanced diet. Where people needed assistance with meals being prepared and with eating, the staff provided this support. Menus were discussed with people, seeking their opinion and preference, in line with any medical needs. This was documented. We saw one person's care plan very clearly identified what foods the person was unable to eat. The manager told us and provided examples of meals that staff had to support the person with as they could cause serious health issues for the person if eaten. We saw that staff were encouraged to read any readymade meal packaging,

and consider how to cook fresh foods. The person's family told us that this allowed the person to "remain safe", and the family "relied on the staff to support the person with all meals."

We saw evidence of good working between the staff team and visiting agencies. When health professionals were visiting people, the service encouraged them to document what the outcome of the visit was, so to ensure the staff practice was reflective of any changing health needs. The service had also developed a working in partnership model with families and people. This focused on allowing people to have ownership of the service and the staff recruited within this. The service had asked for people and their families to be involved in the recruitment process, by writing questions, and analysing these following interview. This had allowed families and people to feel both engaged and involved in the development of the service..

Staff understood the principles of the Mental Capacity Act 2005 (MCA). They told us they had received training in the MCA and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. All staff stated how they asked for permission before doing anything for or with a person. People's rights to make their own decisions, where possible, were protected.

The requirements of the Court of protection were being met. The Court of Protection provide legal protection for vulnerable people who are, or may become, deprived of their liberty in their own homes. The service ensured that where necessary applications were made. Best interest decisions were made, as required and fully evidenced within people's files.

Good

Is the service caring?

Our findings

People were provided support and care consistently by a caring staff team, that although was relatively new, strive to keep people at the centre of their practice.

The management team spoke of the importance of developing relationships with people and their families. Staff and relatives agreed saying the service strived towards developing relationships that enabled care to be delivered in a positive way to people. Staff told us that this allowed people and their relatives to feel safe and confident to raise concerns and issues that were important to them. People were continually enabled the opportunity to request care delivery in the manner that they wished. Meetings were arranged with people and their families to discuss the care plan and general support provided by the service.

The service supported people to maintain and develop their independence. Care plans included information about how people were supported to make decisions and keep as much control over their lives as possible. For example, people were encouraged to use technology as means of communicating and complete online shopping when they were unable to go out. Detailed risk assessments supported people to live their life as independently and as safely as possible. Examples included accessing the community, attending excursions, and completing independent tasks in the home.

The staff team understood the need to respect people's privacy and dignity. Staff ensured that people had their privacy maintained whilst they were supported with personal care. Staff described ways in which this was achieved, for example, by covering a person up, ensuring curtains were drawn and doors closed. Support plans included positive information about the person and were detailed in how to maintain a person's dignity.

Staff continued to meet people's diverse physical, emotional and spiritual needs. The service had a strong culture of recognising equality and diversity amongst the people who resided at the service and the staff who worked at the service. The management used staff diversity to meet the needs of people. For example, people were paired with staff who shared similar interests. The service had an equality and diversity policy. Further training had been completed on this area for all staff, with key topics discussed during team meetings. The service was committed to meeting people's specific needs, for example, religious attendance, family occasions, cultural needs.

The staff and management team understood the importance of confidentiality. People's records were kept securely and only shared as required. The service was preparing for the new General Data Protection Regulations (GDPR) with a new policy having been written to be discussed and shared with staff.

Good

Is the service responsive?

Our findings

People receiving a service and any potential new referrals had their needs assessed prior to support being offered to them. A member of the management team visited the person and discussed their support needs before they started to use the service. Where appropriate, family members were asked to provide information. Staff were given an induction by the relative or person on how they wished to have support from the agency. The management had recently changed the care plans to ensure that all elements of care and support could be appropriately documented. The information from the initial assessment, the induction from families and people was used to write the care plan.

Care plans were very detailed including important information about the person and step by step guidance of their support. Staff reported the new care plans were better and detailing how people needed to be supported. We were told, "They [care plans] don't leave room for error." One relative reported, "The staff support [name] how we did, if not better." We saw evidence of reviews being completed within the care files that had inevitably led to the new documentation being created. People and their relatives were contacted for either face to face meetings, or sent a draft copy of any updated paperwork following a review where amendments to documents was needed.

The service met the Accessible Information Standards (2016), which is a new legal framework under the Equality and Diversity Standard. This legislation focuses on the need to provide communication to a person that is within a format that they can understand. The service prepared documents in formats that were understood by the people receiving support. For example, we were shown pictorial service user handbooks and large printed fonts. People had their needs met, with correspondence being circulated in larger fonts as required and requested. Each care plan was created in two formats. One was service user friendly, and used a pictorial format with writing in large clear font, whilst the other version for staff contained the same information but in a smaller font and without pictures.

The service had a complaints procedure in place, and people were aware of how to make a complaint. We saw that complaints received were appropriately logged and responded to as required. The management completed an investigation and advised the person of the outcome of the investigation. If they were not happy with the outcome they were offered an opportunity to raise any issues, after which the complaint was closed as resolved. Staff told us that they knew what the protocol was should a person complain to them. They told us that they would try to resolve it whilst with the person. However, if this was not appropriate then this would be referred this to the office so that a thorough investigation could be completed.

We saw that the service had received compliments from families and professionals. One professional said, "A good service that aims at working with the person to reach their goals". Another professional stated, "They are very responsive in meeting [name]'s needs… highly recommend them." Relatives had similarly stated, "They are very good with my [relative]."

The service considered ways to help reduce people's isolation, recognising that for some people, the service may be their only contact with the community. They tried to encourage people to develop links with the

local community, suggesting places they could visit, where feasible offering to accompany people. One person who rarely left their home, had agreed during the second day of our inspection to venture out of their home. Staff had encouraged and motivated the person to access the community, something the person was always apprehensive of doing. Staff had contacted the management to tell them the "positive news".

The service did not currently provide support to anyone on end of life care. If the need arose the management would invest in training to ensure this service could be provided as required. The care plan in this area was also being developed.

Requires Improvement

Is the service well-led?

Our findings

We found that the management and leadership required improvement. It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. The manager was newly appointed to the role and was to commence the registration process with CQC. The service was first registered in May 2017. The service had two registered managers in place however they left in December 2017. A new manager was subsequently appointed who commenced the process of CQC registration, however due to unforeseen circumstances, withdrew their application. This meant that the service had operated for the last 12 months with inconsistent managerial support. Whilst a service manager had an overview of the service, this was limited. The service manager was the registered manager of a service at a different location that required their presence.

The lack of consistent management had led to issues arising within the staff team For example, we found staff had resigned and cited a lack of direction from management. Other reasons provided for the exodus included "lack of consistent management", "new management" and the service vision having changed. As a result, the service needed to bring in agency staff to continue operating. The managerial support was put in at point of crisis, rather than consistently when the registered managers left in December 2017. It was acknowledged that managerial support should have been put in place sooner.

Bracknell Supported Living Service has been operating a supported living service for just over 12 months. The service aims to offer care to people in a consistent and safe way within people's own homes. The service had not had a registered manager since December 2017, although two managers had been appointed since then, with one resignation. The newly appointed manager had been in situ for approx. four weeks. Staff reported positive feedback about the new manager and management team. One staff reported, "They seem very good. Always at hand, and very approachable". Another member of staff spoke of the service and manager being transparent and open to ideas and change. They said, "She is very honest about things, wants to work with us [staff]… it will be a new culture for the service." The manager and staff needed to demonstrate consistency. With the team being relatively new, we were unable to determine whether the changes were sustainable by the service.

We saw evidence of governance systems within the operations of the service. The service had an internal audit system in place that rated the service in a similar way to CQC. We noted that the last inspection had been completed in July 2017, with the service internally requiring improvement. The lack of continuous auditing, had led to issues regarding medicines competency not being picked up and missing information within the employment files not being noted. The new manager had completed an audit and created a comprehensive action plan, following their recruitment. This highlighted the areas for development moving forward and how the service aimed to achieve this. The manager acknowledged that staff morale was low, however felt that the changes that were being implemented would improve staff optimism. Two of the staff we spoke with reiterated this point. They said, "There has been considerable change, but I think this will be for the best". Another said, "The service is having to start again, new beginnings will bring good change."

There was management on call systems and staff had access to the management team at all times should

they need them. Systems were in place that meant if they could not get through to one manager, a second was available. The office management team had frequent meetings to handover any information that may be pertinent. This was then discussed as needed with the appropriate staff updating them as required.

Staff reported that they were kept up to date with any changes that were occurring within the service. The new manager and staff team demonstrated commitment in ensuring equality and inclusion within the workforce. They reported the need for all staff to feel equal regardless of their faith, ethnicity, sexuality and disability. Staff were supported with monthly supervisions, probationary meetings and annual appraisals. In addition, team meetings were held monthly to discuss and update staff on any operational issues. Staff were encouraged to use the electronic intranet the service had developed that further provided information, for example updated policies and procedures.

The service sent out surveys and made telephone enquiries on how the person was being supported by the staff team. In addition, meetings with people took place, with the last on 25 April 2018. These meetings focused on seeking feedback on care, staff, documentation and improvements the service could make. During the April meeting care plans were discussed. As a result of the meeting, new paperwork was developed that was detailed in how people wished to be 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 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not ensured that staff employed to carry out the regulated activity were fit and proper to do so in line with Schedule 3. Regulation 19 (1)(b)(c)(3)(a)