Support 2 Independence

The Italian Lodge

Inspection report

88 Park Road South
Prenton
Merseyside
CH43 4UY

Tel: 01516539094

Date of inspection visit:
28 October 2016

Date of publication:
07 December 2016

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

We carried out an announced inspection of The Italian Lodge on the 28 October and 3 November 2016.

The Italian Lodge is the head office of Support 2 Independence and is situated in the Prenton area of Merseyside. The location is registered as a domiciliary care agency and provides support to people living in their own tenancies in the community with learning disabilities, acquired brain injuries and/or mental health needs. A varying level of support is provided depending on people's individual need.

A registered manager was in post and had been since 2011.. 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.

We last visited this service on 29 January 2014. At that time the registered provider met all the regulations we used to assess the quality of support.

People told us that they felt safe with staff team ad felt that their financial interests were safeguarded. Staff demonstrated a good understanding of the types of abuse that could occur and how any concerns could be reported. Staff were aware of how to report concerns to external agencies.

The process for recruiting staff was robust and subject to checks which assessed their suitability to carry out their role. Staffing levels were maintained.

The registered provider took the risks faced by people in their support into account and these risk assessments were up to date and agreed by people who used the service.

People told us that the staff team knew how to support them effectively. Staff had received training relevant to the needs of people who used the service and received regular supervision and appraisals which staff considered to be constructive. Staff were aware of how the capacity of people should be assessed and how this impacted on people's daily lives.

The nutritional needs of people were taken into account and people were encouraged to follow a healthy eating lifestyle and staff supported them in this.

People told us that the staff team were caring. Staff were aware how the privacy of people of people should be promoted and how confidentiality in respect of personal information could be maintained.

People received information on how they were to be supported and felt involved in the planning of their support.

Care plans were personalised, up to date and presented in a format which assisted people to understand the support they should receive. People felt that they were in control of their support. People were able to pursue work and educational activities with staff support. People knew how to make a complaint.

The registered provider assessed the quality of the support they provided and enabled people who used the service to comment on the standard of support.

The registered provider co-operated with external agencies and sought accreditation from agencies who championed the needs of people who used 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?

Good

The service was safe

People told us they felt safe with the staff team and felt their financial interests were safeguarded.
Staff had received training in safeguarding
Recruitment processes were robust.
The management of medicines was safe.
Risks faced by people were up to date and comprehensive.

Is the service effective?

Good

The service was effective.
People had confidence in the skills of staff to support them.
Staff received training and appropriate supervision to assist them in their role.
The registered provider was conversant with the Mental Capacity Act 2005 and included the principles in care practice.
The nutritional needs of people were met.

Is the service caring?

Good

The service was caring.

People felt cared about and that staff supported them in a positive way.

Staff demonstrated a commitment to ensuring that people achieved aims on their lives.

People were involved in their supported

Information was given to people to assist them in making decisions about their lives.
The health needs of people were promoted.

Is the service responsive?

Good

The service was responsive.

Care plans were very personalised, able to be understood by people who used the service and reviewed on a regular basis.

People were able to access work and education with the encouragement and support of the staff team.
Complaints were listened to and acted upon.

Is the service well-led?

Good

The service was led.

People knew who the registered manager was and considered them to be helpful. Staff told us that the registered manager was supportive.
The registered provider measured the quality of the service it provided with the inclusion of the views of people who used the service.
Records were up to date and accurate.
The registered provider sought the views of external agencies to comment on the support provided.

The Italian Lodge

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 28 October and 3 November 2016 and was announced. 48 hours' notice was given to the agency of our intention to visit so that we could be sure that staff were available to assist us.

The inspection was carried out by one adult social care inspector.

As part of our inspection, we ask registered providers to complete 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 improvements they plan to make. The PIR was returned to us when we asked.

We contacted local authority commissioning groups and the local safeguarding team about information they held in respect of the registered provider. They did not have any concerns.

We reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at six care plans and other records such as four staff recruitment files, training records, policies and procedures, quality assurance audits and complaints files.

We spoke to eight people who used the service. Discussions were held by visiting people in their homes. During these visits we were able to observe interactions between staff and people who used the service. We spoke to four members of staff as well as the registered manager, training officer and the managing director.

Good

Is the service safe?

Our findings

People told us "I feel safe with the staff team", "I feel safe living here" and "I feel that I can trust staff when they help me with my money". People said that where staff assisted with medication, people always received it when they needed it and that it was never missed. They said that there was always staff around to help them and that they could call them when they needed it.

Staff demonstrated a good understanding of the types of abuse that could occur and confirmed that they had received training in protecting vulnerable adults from harm. They outlined how any concerns they had would be reported and were confident that action would be taken. They also confirmed that they would make referrals themselves if needed. Staff provided a good account of how if they had concerns about care practices they could be referred to external agencies such as the police, the local authority and the Care Quality Commission. They confirmed that a whistleblowing procedure was available to them with contact numbers for these agencies. We checked our records in relation to safeguarding and found that the registered provider always informed us of any allegations made. Staff told us that they did not consider anyone to be at risk within the service. They told us that they continually monitored people to ensure that any changes in behaviours could be monitored and acted upon if it meant that people were at risk.

Recruitment procedures were robust. A recruitment policy and procedure was in place. Files contained references to verify the suitability of people to perform their roles. A Disclosure and Barring check had been made on each person. Known as a DBS, this process is designed to check if people had been convicted of offences which would affect their suitability to support vulnerable adults. DBS checks had been obtained before people worked for the service. Staff told us that during their recruitment, a check had been obtained before they had come to work for the registered provider. Other documents were available including job descriptions, references, health checks and application forms. Interview notes were also available demonstrating the values of people to support people. People who used the service had been asked if they wished to be involved in the selection process for new staff. Most had preferred not to although some had been involved. This had enabled the interactions between people and prospective candidates to be observed with a view to matching skills with needs. In addition to this, people's care plans had included a summary form each person of the skills and values that they considered to be important in prospective staff in order to support them effectively.

People told us that staff were always available to provide support to them. They were aware of staff leaving or taking temporary leave as they had always been informed of this. We witnessed staff and managers passing this information on to people who used the service during our visit. Staff were able to give them explanations of who had left and how support would continue. Staff told us that staffing levels were maintained and that they had never been expected to support people with dangerously low levels of staff. Staff rotas were available which confirmed the staff on duty at any one time.

Staff told us that they had received medication training and this was confirmed through training plan and training records. In addition to this staff had their competency to administer medication checked during their induction and during the course of their employment. Details of the medicines prescribed to people

were available in people's support plans and the preferred method for them receiving medication was recorded. Some people told us that they did not receive medication and others told us that they were able to manage these themselves. For people who needed support they told us that the staff team managed their medication and that they were happy with this. People told us that their medication was always there for them when they needed it and that it was never missed. Where people refused medication, this was noted in daily records to ensure that continued refusals could be acted upon if needed. Medication records were appropriately signed and were checked on a daily basis by the registered manager and supervisors to ensure that medication had been administered. People told us that their medicines were safely locked and secured and we saw this during our visit.

The registered provider maintained assessments in relation to the risks faced by people from their environment and during the support they received. The registered provider had adopted a "positive risk taking" approach. This involved weighing up the potential benefits and harms of exercising one choice of action over another, identifying the potential risks involved, and developing plans and actions that reflect the positive potential and stated priorities of the person. All risk assessments seen were up to date and had included details of the individual person it related to. Risks were in place for those environmental issues that could pose a risk as well as activities which took place within each person's home such as cooking and support with cleaning, medication as well as personal security. Other risks identified included activities outside, personal relationships, risks to other people, risk of neglect, self-harm and financial risks. The level of risk was scored and detailed actions were in place within each assessment to identify the actions that staff should take to minimise risk. Where new activities or pursuits had been identified by people, these were encouraged yet details were present which indicated that risks were seen as having positive benefits and not just restrictive ones. Emergency plans were in place for each person as well as risk assessments for staff working alone.

The registered provider had an infection control policy and staff had received health and safety training incorporating infection control. This was verified through talking to staff and by reviewing training records and training planners. People who used the service told us that staff took infection control into account when assisting with support and tidying and cleaning their own home. People who had support in preparing meals told us that the staff always left the kitchen area clean and washed their hands prior to preparing meals.

Good

Is the service effective?

Our findings

People told us "Staff are good and "Staff know what they are doing". They also told us "Staff know what I need and know my likes and dislikes". People were asked for their consent either verbally or by signing to agree to the support they received. People told us that they were involved in food preparation and where staff support was needed, this was done in a patient and hygienic manner.

Staff told us about the training they received. They said that they received regular training and that this covered mandatory health and safety topics as well as subjects which reflected the needs of people who they supported. They told us that training was relevant to their work and they were positive about it. A training matrix was available and this indicated what training had been completed as well as scheduled refresher training. The registered provider employed a training officer who was able to give an overall view of the training provided to us. This included health and safety training as well as medication administration (including specialist training for certain medicines) and safeguarding. Other training had been provided in line with the needs of individuals which included epilepsy awareness, autism awareness and effective communication.

Staff told us that they received supervision almost every month to six weeks. This was evidenced by supervision records. A supervision planner was available identifying when staff were next to receive supervision. Staff viewed supervision as a constructive part of their work and enabled them to assess their own care practice and identify future training needs. In addition to this, staff received annual appraisals. Again staff were positive about this process and staff we spoke with had undertaken an appraisal each year they had worked there. Appraisals were confirmed by records maintained.

A structured induction process was in place for staff. This process was in line with the Care Certificate. The Care Certificate is provided by the Skills for Care organisation and is the start of the career journey for staff and is only one element of the training and education that will make them ready to practice. The induction process included mandatory training in health and safety topics as well as medication administration and safeguarding vulnerable adults. New staff were required to shadow existing staff for two weeks or until such time as they were deemed to be competent in working alone. Staff told us that the induction process had prepared them for their role in supporting people.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the managing director. This process was incorporated into the practice of the registered provider. Steps had been taken to provide training to staff as well as to issue information in relation to how the mental capacity act could affect the people who used the service. While no individual was subject to such deprivations, the managing director was aware of the process and other measures such as appointeeships or the lasting power of

attorney. The assessment and care planning used by the registered provider included reference to the capacity of people to make decisions. Staff confirmed they had received training and were able to outline the broad principles involved.

Some care plans outlined that people had the potential to display behaviours that challenged the service. In those instances, there were detailed records of the circumstances in which these behaviours could occur and develop into a situation where people's safety was at risk. For these people, there was a detailed step by step guide on triggers, how the behaviours could compromise safety and how staff should intervene to protect people.

People told us that they were consulted about their care and support and had their consent gained. This was done verbally although where possible people signed to confirm that they agreed to their support. People we spoke with were able to give consent verbally. Staff told us that they always asked people whether they needed support and did not provide this until consent was given. There were instances when people refused support. People told us that when they did not want support, this was respected by the staff team. In addition to this, staff told us that they would respect any decision yet were mindful of their duty of care. They told us that any continued refusal of support may trigger a further review of people's needs and their plan of care.

The nutritional needs of people were taken into account in the assessment process as well as through care planning. People's care plans outlined their preferences in relation to food as well as any risks that may have been present with people's nutrition. There was an emphasis on healthy eating for people in care plans. While people wanted to have certain foods, there were reminders in place to offer people healthy alternatives. Staff were able to outline how this worked in practice with them prompting people or guiding them to have healthier options. Staff told us that there was no one who was nutritionally at risk although staff kept the healthier choice options in mind when supporting people and providing advice.

Some people we spoke with told us that they needed support in preparing meals. This ranged from complete support to support in shopping and preparing meals. As a result if their involvement in shopping, people told us that they always had what meals they wanted and that these were well presented and well cooked. They told us that the staff team were patient in the support they provided, were conscious of the need to prepare food hygienically and always washed their hands prior to dealing with food.

Good

Is the service caring?

Our findings

People told us they felt cared about and that they received good support from the staff team. They told us that they felt as though they were supported in a respectful and dignified way and that the staff team knew their likes and dislikes. They told us that they were treated as individuals and were provided with all the information they needed to make informed decisions about their lives.

Interactions between people who used the service and staff were informal, respectful and informative. People referred to the staff team with any queries they had or any ongoing support they needed in daily tasks.

Staff were able to outline how the promoted people's privacy and dignity in the support they gave. They gave practical examples of supporting people in personal care tasks such as closing curtains or doors to make sure that people's privacy was maintained. They also told us that they would knock on the door of people's homes and await an invitation in. This was confirmed by people we spoke with who told us that staff never just walked into their homes uninvited. We observed this when we visited people in their homes with people being asked if it was alright for staff to enter their homes.

The registered provider had a confidentiality policy which staff had signed to show their knowledge and understanding of confidentiality. Staff gave us practical examples of how confidentiality and privacy could be promoted. This included times when staff supported people to health agencies for example hospitals or doctors' appointments. Staff told us that they were mindful of maintaining confidentiality within such public settings.

Staff demonstrated a thorough knowledge of the needs of each person. Discussions with staff highlighted specific needs of people that had been confirmed by individuals we had earlier spoke with. Staff demonstrated a commitment to ensuring that people had the opportunity to make positive life choices with risk taken into account. Staff demonstrated a genuine interest in the wishes of people. Advice given was realistic, thorough and reasons were outlined to them if there were any barriers to what they wanted to achieve. Some people had specific interests or wished to pursue specific lifestyles and observations of support confirmed that these were respected.

People felt involved in their support. Each person had a person centred care plan. When these were to be reviewed, the individual would invite those people they wanted to their assist in the review and choices were respected. This was confirmed by the people we spoke with. Other people wanted to have a person centred plan which involved a short summary of their needs. Again this preference was respected. Further evidence of involvement had been in training. In response to people's enquiries, the training officer had enabled people to attend courses tailored to their needs. These courses had included keeping safe, keeping healthy, basic first aid and healthy eating. People told us that this training had been made available and had created a social event in itself for them.

Information was made available to people who used the service either verbally or through written form. A

tenant's forum was available locally with people confirming that they had the choice to attend these if they wished. Some people found them useful while others did not but they confirmed that the opportunity was there to attend if they wanted to. In addition to this, the registered provider had a general tenant's forum for all people who used the service in different locations. People had the opportunity to have news relating to themselves, purchases, holidays or other activities published. This provided a sense of involvement for people able to let others know of positive things that had happened to them. The communication needs of people were taken into account when information was given. Care plans were accompanied by pictures and symbols as well as text to outline needs. Other documents such as health passports, complaints procedures and tenant's handbook had been presented pictorially to support people's understanding of key information.

The health needs of people was taken into account. Assessments provided information on key health issues and this extended to care plans. Where health needs had changed, there was evidence that these had been taken into account and care plan changed accordingly. Some people had developed health issues which affected their daily lives Steps had been taken by the registered provider to enable specific health pathways to be developed to better assist in meeting health needs and providing information to people. A health passport had been developed for those who needed to be admitted into hospital. This outlined key needs and preferences for health professional to refer to as an aid to the daily lives of people. People told us that they were able to access health professionals and these were done either routinely or in response to some health issue. Records of these were maintained and outcomes noted. People told us that they had the choice to attend such appointments alone and this was respected. In other cases, people preferred direct support form staff to attend these.

The care planning and risk taking approach used by the registered provider enabled people's independence to be respected and promoted. The areas where people wished to be independent in the longer term were recorded on care plans and risk assessments were used to assess the potential risks faced through the pursuit of activities or aspirations. People were able to access the local community independently and pursue their own routines as a result. In order to promote safety, the staff team encouraged people to tell them where they would be.

Good

Is the service responsive?

Our findings

People told us that they had seen their care plan, understood it and were fully involved in everything that had been recorded in it. People told us that they had been supported to try new activities such as college courses and voluntary work to broaden their experiences. People knew how to make a complaint. They told us that they were confident that the staff team would listen to any concerns they had and act on them.

The service undertook an assessment process of the needs of individuals prior to them receiving a service. Assessment information was thorough and covered all the main needs of people in relation to all aspects of their daily lives. Risks unique to each person relating to daily living had been included within this assessment information.

This assessment information was translated into a plan of care. The registered provider named these as personal care plans (PCPs). All care plans were personalised in nature, outlining a detailed account of each person's daily lives, needs and aspirations. In those instances where assessment information outlined significant and complex needs, the personal care plan was more detailed in outlining strategies for staff to respond to given situations. Two care plans provided a breakdown of all the staff actions needed to support people in public places. These situations presented a risk to people yet the care plan encouraged people to still access the community with a step by step guide for staff to cover all eventualities. All care plans had images, photographs and symbols to ensure that the content of plans could be readily understood by the people they referred to. Some people had preferred their support plan to encompass a one page summary in line with their personal wishes and this had been respected. These requests had related to people whose needs were very significant and complex and as a result required more detailed care plans. The summaries were still made available although the registered provider retained other information outlining these complex needs in agreement with each person.

The main part of care plans were intended for the person they referred to. Other information was available for staff to refer to linked to the main summary of need. These included support with medication, dealing with changes in health needs, dealing with behaviours that challenged the service and other risk assessments specific to the person.

All care plans had been reviewed during a twelve month period. When care plans were due for review, people were provided the opportunity to invite significant others in their lives to assist with the review process. All people we spoke with had had that opportunity. These wishes of people were paramount. An ongoing process of past reviews and achievements are included on each plan of care. Where needs changed, care plans became a "live" document with changes made where necessary.

Included within care plans were work and education opportunities for people. These activities were confirmed by people we spoke with. People had been supported into finding work; either paid or voluntary and received different and appropriate levels of staff support in this. Other had accessed college courses.

A complaints procedure was available. This had been presented in a format appropriate to take all needs into account. The complaint procedure was clear and outlined who to speak with and how complaints would be investigated. Complaints had been received since our last visit. There was evidence that these had been responded to with outcomes reached to the satisfaction of the complainant. Other complaints had not been related to the conduct of the service rather than in dealing with complaints and disagreements between people who used the service and their neighbours. These were still investigated by the service in order to resolve disagreements.

Good

Is the service well-led?

Our findings

People told us that they knew who the registered manager of the service was and that they were "Helpful", "Nice" and "Approachable". People told us that the staff team were good at what they did and supported them in their daily lives. People told us they were given the chance to comment on the support they received.

A registered manager was in post. In addition to the registered manager, there was a structure of management in place to ensure that accountability for the running of the service was included in the way the agency operated. Staff told us that registered manager was approachable and supportive to them.

The registered provider had systems in place for measuring the quality of the support it provided. Personal audits had been completed on documentation relating to each person who used the service. These were conducted throughout the year. Audits made reference to care planning documentation, risk assessments, medication and health passports. Audits included a summary of the issue that needed addressing, who needed to address it and a timescale for action. Where action had been completed, this was signed by staff and further checked to ensure that people received a well led service.

The registered provider asked people who used the service for their views on the support they received. This had been completed in 2016. The results of the questionnaire were fed back to people who used the service in an easy read format. Percentages of how satisfied people were outlined in the feedback and covered areas such as how happy people were with the support provided, their opportunity to make decisions, the relationships they had with staff, whether they were consulted and felt safe. Included in this feedback was a summary of how the service could be improved. People we spoke with had the opportunity to complete a questionnaire while others had preferred not to and some did not recall being asked. People we spoke with were able to confirm that staff did ask how support was through their daily interactions.

The registered provider had issued a number of policies and procedures providing staff and people who used the service with information on the aims and approaches the agency would use. These covered a range of issues such as health and safety, safeguarding, consent and complaints. All policies and procedures had been updated in 2016 and clearly indicated when they would be reviewed again. Procedures were devised in an easy to read format to meet the communication needs of people. People we spoke with had the opportunity to attend a tenant's forum with the aim to share suggestions to influence the running of the service and the support they received.

All records seen were up to date and accurate. Care was taken to ensure that confidential information was kept secure.

The registered provider had co-operated with other agencies in the running of the service provided. A Local Authority officer had visited the service to assess the quality of support provided earlier in 2016 and their findings were positive. The registered provider had also sought accreditation with the National Autistic Society (NAS) to see if the support to people living with this condition had their needs met. The NAS had

produced a report which involved a detailed account of their findings and interactions between staff and people who used the service. The result of this was that the registered provider had been granted accreditation with the NAS.

Our records indicated that the registered provider always notified us of any incidents that had occurred and the conditions of registration we applied to the service were being adhered to. The registered provider sent us a provider information return form when we asked them to. This was completed outlining current and future intended practice.