Lifeways Natural Networks Limited

Natural Networks - Individualised Support Service

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This announced comprehensive inspection took place on 8 January 2018.

At the previous inspection we found breaches of regulation in relation to; the need for consent and good governance. As part of this inspection we checked to see if the necessary improvements had been made and sustained.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions; Effective, Responsive and Well-led to at least good. We found that improvements had been made in accordance with the action plan in each of the key questions. The service was now meeting regulatory requirements.

This service provides care and support to people living in two 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

A registered manager was in post. 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.

At the last inspection in November 2016 we identified a breach of regulation 11 (Need for consent) because there were no suitable arrangements in place for obtaining consent and acting in accordance with the Mental Capacity Act (2005). As part of this inspection we checked records to ensure that improvements had been made and sustained in accordance with the provider's action plan.

The records that we saw indicated that the service operated in accordance with the principles of the MCA. It was clear from care records and discussions with people that consent was sought and recorded in relation to care and treatment. People's capacity to consent to care was assessed and recorded.

The provider was no longer in breach of regulation 11 regarding the need for consent.

At the last inspection in November 2016 we identified a breach or regulation 17 (Good governance) because the provider had failed to maintain an accurate and contemporaneous record in respect of each person receiving a service. As part of this inspection we checked records to ensure that improvements had been made and sustained in accordance with the provider's action plan.

The care records that were held within the person's own home contained the same information as those in the registered office and were supplemented with daily notes. The daily notes were respectfully worded and

provided staff with important information about; health, activities, sleep-patterns etc.

It was clear from the records that we saw that improvements had been made and sustained in accordance with the provider's action plan.

The provider was no longer in breach of regulation 17 regarding good governance.

People spoke positively about the safety of the service provided. We saw that the service had well-developed and extensive systems for protecting people from the risk of abuse or neglect. The staff that we spoke with were clear about their responsibilities in relation to safeguarding and said that they would not hesitate to report any concerns to their managers or externally (whistleblowing) if necessary.

The care records that we saw clearly demonstrated that risk was assessed and reviewed to keep people safe. It was equally clear that positive risk taking was encouraged to help people to develop their skills and independence.

The records that we saw provided evidence that staff were safely recruited and deployed in sufficient numbers to keep people safe. Each of the records contained a recent Disclosure and Barring Service (DBS) check, photographic identification and two references.

The service adhered to best-practice guidance for supported living services in relation to the administration of medicines. People had individual arrangements in place for the storage and administration of their medicines. Staff received training and had their competency to administer medicines assessed regularly.

We saw from records that staff were regularly trained in a range of health and social care topics including; administration of medicines, health and safety, infection control, adult safeguarding and the MCA. We also saw that additional, specialist training was provided to ensure that staff had the skills, competencies and knowledge to support people in accordance with best-practice.

People were supported to access a range of community-based healthcare services in accordance with their needs. This included; GP's, chiropodists, dentists and services to meet specific healthcare needs.

People receiving support and relatives spoke positively about the quality of care and relationships with staff. It was clear from our observations and discussions that staff knew people well and treated them with kindness and respect.

People were encouraged to express their views regarding the service and were involved in decision-making at every level. One of the people who received a service did not use speech. Staff were able to communicate with them by use of Makaton (simplified sign language) signs and through monitoring body language, facial expression and behaviours.

People's right to privacy and dignity were maintained in all aspects of care and support. Staff understood how people's behaviours sometimes compromised their dignity in community settings and were vigilant in monitoring people and intervening as early as possible.

Staff promoted regular contact with families through visits and telephone conversations. Relatives told us that they were always made to feel welcome by staff when visiting.

Needs relating to disability, culture and religion were clearly defined in care records. Where required,

support plans provided clear instruction for staff in relation to; the need for routine, preparation of food and the provision of personal care.

People were supported to access a range of activities within their own communities in accordance with their wishes. Examples of activities included; attending church, ten-pin bowling, bingo and meals out.

We saw from care records and promotional materials that the service recognised the need to adapt communications to meet the needs of individuals. In adapting its approaches in this way, the provider was meeting the Accessible Information Standard.

Relatives and staff spoke positively about the management of the service and the quality of communication. People using the service, their relatives and staff were engaged through regular meetings. Examples included; service user focus groups, management meetings and staff awards. The service also made use of social media to communicate and invite comment.

The registered manager was aware of their role and responsibilities both within the service and with regards to their registration. Notifications to the Commission had been submitted as required and the action plan arising from the last inspection had been completed in accordance with the agreed schedule.

The service had a robust approach to the management of safety and quality. Regular audits were completed by staff and managers at all levels. A specialist quality team provided oversight of the processes and monitored completion.

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.

Systems and processes were effective in monitoring safety and protecting people from harm.

Risk was appropriately assessed and reviewed without unnecessarily restricting people's independence.

Staff were safely recruited and deployed in sufficient numbers to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were trained in a range of relevant subjects and provided with regular supervision.

The service operated in accordance with the requirements of the Mental Capacity Act 2005.

Staff worked effectively with other organisations to ensure that people were supported to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People spoke positively about the quality of relationships and the caring nature of staff.

Staff ensured that people were able to express their preferences and exercise choice.

Staff were aware of people's right to privacy and dignity and provided support accordingly.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was recorded in appropriate detail in their care records.

The service had a robust complaints procedure, and people receiving support and their relatives understood how to complain.

Is the service well-led?

Good

The service was well-led.

The service had responded positively and in a timely manner to issues arising from the previous inspection.

The service had a clear vision and set of values that reflected best-practice in supported living services.

The service had a robust approach to safety and quality auditing that identified issues and resulted in action.

Natural Networks - Individualised Support 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 checked 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 8 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we wanted to meet with people using the service and they are often out during the day.

The inspection was conducted by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority for information.

A Provider Information Return (PIR) was available for this service. 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 all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with one of the two people using the service, relatives and staff.

We also spent time looking at records, including two care records, four staff files, medication administration record (MAR) sheets and other records relating to the management of the service.

On the day of the inspection we spoke with two relatives over the telephone. We also spoke with the registered manager, a service manager, a team leader and four support workers.

Good

Is the service safe?

Our findings

People spoke positively about the safety of the service provided. Comments included; "I like my support because I can go out", "Yes I feel [relative] is safe there", "[Relative] is safe due to being so well looked after by the staff. They keep [relative] safe and I know that [relative] is happy there." Staff also explained how they acted to keep people safe. Their comments included; "I make sure that I give appropriate medicines at the appropriate time. I also keep good standards of health and safety, which includes making sure their environment is safe for them. We have a telephone number to call if there are any safeguarding issues."

We saw that the service had well-developed and extensive systems for protecting people from the risk of abuse or neglect. Staff were trained in adult safeguarding and had access to policies, procedures and local contact information to guide them if they suspected abuse or neglect. The staff that we spoke with were clear about their responsibilities in relation to safeguarding and said that they would not hesitate to report any concerns to their managers or externally (whistleblowing) if necessary. The registered manager told us that the monitoring of incidents and accidents was used as an opportunity to look for unusual behaviours that might indicate abuse or neglect. There had been no safeguarding incidents reported in the previous 12 months.

People were afforded further protection against abuse in relation to protected characteristics because appropriate detail and guidance for staff was included in care records. For example, one care record gave staff specific instructions regarding the preparation of food to ensure that the person's religious beliefs were not compromised. The instructions included guidance for staff in the preparation of the person's food and also instructed them not to prepare food for their own consumption in the person's home which contradicted the person's beliefs. By doing this the provider ensured that cutlery, crockery and utensils were not used inappropriately.

The care records that we saw clearly demonstrated that risk was assessed and reviewed to keep people safe. It was equally clear that positive risk taking was encouraged to help people to develop their skills and independence. For example, one person with mobility difficulties was encouraged to walk independently with close support and monitoring from staff to avoid developing a reliance on the use of a wheelchair. Other areas covered by risk assessments and associated support plans included; choice and control, health and wellbeing, everyday tasks and managing money.

The records that we saw provided evidence that staff were safely recruited and deployed in sufficient numbers to keep people safe. Each of the records contained a recent Disclosure and Barring Service (DBS) check, photographic identification and two references. DBS checks are used by employers to check if employees are suited to working with vulnerable adults. We saw evidence that people were involved in the recruitment and selection of new staff. This ensured that their needs and preferences were considered as part of the process. The records that we saw showed that regular staff had been provided in accordance with people's individual needs and their commissioned hours. In one case commissioners were looking to reduce a person's hours. The service was working closely with the commissioners and an independent advocate to ensure that the risk of reducing the commissioned hours was fully considered before a decision

was finalised.

The service adhered to best-practice guidance for supported living services in relation to the administration of medicines. People had individual arrangements in place for the storage and administration of their medicines. Staff received training and had their competency to administer medicines assessed regularly. They were required to complete medicines administration record (MAR) sheets. The MAR sheets that we saw had been completed fully and accurately. The service had a clear medication policy which detailed procedures for the administration of PRN (as required) medicines, covert medicines (disguised in food or drink in the person's best-interests), topical medicines (creams), over-the-counter medicines and controlled drugs. Controlled drugs are medicines with additional controls in place because of their potential for misuse. Neither of the people receiving support at the time of the inspection was receiving covert or controlled drugs.

All medicines' practice was audited on a regular basis by senior staff and managers. Where errors were identified appropriate action was taken to monitor and improve safety and compliance.

People were protected from the risk of infection by staff who were appropriately trained. Staff were provided with personal protective equipment (PPE) such as gloves and aprons to wear when they supported people with personal care.

Accidents and incidents were recorded in sufficient detail and were analysed by senior managers to establish if any patterns or trends emerged. Because only two people were being supported at the time of the inspection there were no significant incidents available for assessment. However, we were told about historic improvements made to ensure people's safety. For example, a person who was moved to ground floor accommodation following a series of falls. We also saw and were told about how staff monitored the physical environment of one person who had an extensive collection of CD's, DVD's and memorabilia. Staff ensured that everything was stored safely and in a manner which didn't compromise a safe exit in the event of an emergency.

Good

Is the service effective?

Our findings

At the last inspection in November 2016 we identified a breach of regulation 11 (Need for consent) because there were no suitable arrangements in place for obtaining consent and acting in accordance with the Mental Capacity Act (2005). As part of this inspection we checked records to ensure that improvements had been made and sustained in accordance with the provider's action plan.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. In supported living services applications must be authorised by the Court of Protection.

The records that we saw indicated that the service operated in accordance with the principles of the MCA. It was clear from care records and discussions with people that consent was sought and recorded in relation to care and treatment. People's capacity to consent to care was assessed and recorded. However, the service also considered what each person could safely do independently as part of the support planning and risk assessment process. For example, in relation to managing money and personal care.

The provider was no longer in breach of regulation 11 regarding the need for consent.

Staff told us they received the right training and support to meet people's needs. Comments included; "Training is good. I have had enough training. I have supervision once every three months and appraisal every 6 months", "The training they gave me was good. I completed a care certificate. I go to the manager and team leader for any support I need in my job" and "I receive supervision once every three months. I think I have learnt more on the job than by the training but it does help." However, two staff did state that they needed more training regarding the MCA and DoLS.

We saw from records that staff were regularly trained in a range of health and social care topics including; administration of medicines, health and safety, infection control, adult safeguarding and the MCA. We also saw that additional, specialist training was provided to ensure that staff had the skills, competencies and knowledge to support people in accordance with best-practice. This training included; positive behaviour support, autism and epilepsy. New staff were trained in accordance with the principles of the Care Certificate. The Care Certificate requires staff who are new to health and social care to complete a programme of learning and have their competency assessed within 12 weeks of starting.

Policies, procedures and audit processes reflected best-practice and current legislation. For example the National Institute for Health and Care Excellence (NICE) guidance in relation to the administration of

medicines and the Care Quality Commission's key lines of enquiry.

People were supported to eat and drink in accordance with their preferences. Where safe and appropriate, people were supported to shop for and prepare their own meals and drinks. One person told us, "I choose my own meals." Another person had specific dietary needs in relation to their religion. The care records that we saw contained very specific guidance for staff regarding the sourcing, preparation and serving of food and drinks. For example, 'I must not eat pork, beef or any other red meat.' Instructions were extended to ensure that staff did not prepare or eat red meat in the person's presence. A relative said, "They [staff] make sure that [relative] does not eat meat and also they don't eat any meat products in front of [relative]."

Neither of the people supported by Natural Networks had recently moved between services. However, the registered manager and senior staff that we spoke with understood the need to share information to ensure a safe and smooth transition if it was required. For example, each person had a health passport and/or health action plan which contained important information for healthcare professionals.

People were supported to access a range of community-based healthcare services in accordance with their needs. This included; GP's, chiropodists, dentists and services to meet specific healthcare needs.

We were only able to visit one of the two properties where support was delivered, but it was clear that the person's home was adapted and decorated in a manner of their choosing. We saw that the walls were covered in photographs and posters representing their favourite football team and singer. This provided a high level of stimulation and reflected their personality.

Good

Is the service caring?

Our findings

People receiving support and relatives spoke positively about the quality of care and relationships with staff. Comments included; "The staff are nice. They do what I want them to do. Yes the staff are good. I'm happy with everything", "They keep [relative] safe and I know that [relative] is happy there. The staff and my [relative] have a good rapport and they chat to [relative] and keep [relative] interested and happy" and "The staff have known [relative] for many years and my [relative] has got a strong bond with them. They are very caring with [relative]."

We were able to observe staff interacting with one person and spoke extensively with other staff. It was clear from our observations and discussions that staff knew people well and treated them with kindness and respect. We saw examples of staff engaging in light-hearted conversations with the person. They responded positively and clearly enjoyed the exchanges.

People were encouraged to express their views regarding the service and were involved in decision-making at every level. For example, one person was in the process of having their commissioned hours reviewed by the local authority. Staff and managers had expressed concern that any reduction would compromise the person's safety and the quality of the service. To ensure that the person's views were accurately and objectively represented, the person had secured the services of an independent advocate with support from staff and the local authority. In another example, we saw a record of how staff had worked with a person to plan a holiday taking into account; costs, accessibility and risk.

One of the people who received a service did not use speech. Staff were able to communicate with them by use of Makaton (simplified sign language) and through monitoring body language, facial expression and behaviours. A relative of the person and staff explained that these arrangements were particularly effective because staff knew the person's routines and behaviours. One member of staff said, "We can predict things before they happen. It's because we know people so well."

The commissioning and provision of staff hours meant that people always had access to support when they needed it. Staff were able to respond to people's needs and preferences immediately. The availability of familiar staff gave people the confidence to maintain and increase their independence through positive risk taking. We saw examples where people had achieved improved levels of independence in relation to; mobility, management of finances and person care.

People's right to privacy and dignity were maintained in all aspects of care and support. Staff understood how people's behaviours sometimes compromised their dignity in community settings and were vigilant in monitoring people and intervening as early as possible. Staff were also clear in their duty to respect people's privacy and dignity when providing personal care. Confidential information was stored securely and discretely.

Staff promoted regular contact with families through visits and telephone conversations. One person had experienced anxiety relating to family contact which threatened to compromise the frequency of visits. We

heard evidence of how staff had worked creatively to reduce the level of anxiety to ensure that important contact was maintained.

Relatives told us that they were always made to feel welcome by staff when visiting. One relative said, "I feel welcome whenever I go there. They pick me up and I have no problem arranging that." While another person told us, "I am welcome at any time."

Good

Is the service responsive?

Our findings

At the last inspection in November 2016 we identified a breach or regulation 17 because the provider had failed to maintain an accurate and contemporaneous record in respect of each person receiving a service. As part of this inspection we checked records to ensure that improvements had been made and sustained in accordance with the provider's action plan.

Care records for each person were stored in two primary locations; the registered office and the person's own home. We were able to inspect the records for both people receiving support at the registered office, but were only able to view one set of records in a person's home because the other person was not available at the time of the inspection.

The care records held at the registered office contained essential information, copies of support plans and risk assessments. The documents indicated how the person had been involved in discussions about their care and support and in some cases were signed and dated. We saw support plans and risk assessments relating to; choice and control, health and wellbeing, everyday tasks and living safely and taking risks amongst others. Each plan was sufficiently detailed to inform staff practice and showed evidence of regular review. Care documents were written in the first person and included person-centred information. For example, one person's records stated 'I know what I like. It is important to me that staff allow me to make my own choices by offering me a range of options.' This approach to the production of information helped to ensure that the person's needs and wishes were given priority in the provision of care and support. Staff had signed the records to indicate that they had read them.

The care records that were held within the person's own home contained the same information as those in the registered office and were supplemented with daily notes. The daily notes were respectfully worded and provided staff with important information about; health, activities, sleep-patterns etc.

It was clear from the records that we saw that improvements had been made and sustained in accordance with the provider's action plan. The provider was no longer in breach of regulation 17.

Each of the care records that we saw contained a good level of personal detail including; personal histories, relationships, behaviours, routines and health conditions. This helped staff to get to know the person and better meet their needs. The staff that we spoke with knew people well and told us that the care records were an important source of information when they first started working with someone. The records were produced with a clear emphasis on positive attributes including; what the person could do for themselves and what people valued about them.

Needs relating to disability, culture and religion were clearly defined in care records. Support plans provided clear instruction for staff in relation to; the need for routine, preparation of food and the provision of personal care. For example, one record instructed staff regarding days when aspects of personal care must not be given in accordance with the person's religion. A relative told us, "My [family member] has religious requirements and the staff respect our Indian religion. They take [family member] to the Hindu Temple."

Goals and aspirations were clearly defined and reviewed in care records. Because of the nature of people's disabilities, progress towards objectives was sometimes slow or difficult to measure. The staff that we spoke with recognised that the smallest progression was important and should be recognised. We were told that one person had made significant progress in relation to independent personal care which had greatly improved their quality of life. This was evident in the care records that we saw.

People were supported to access a range of activities within their own communities in accordance with their wishes. One person attended a day service and visited family on a regular basis, while the other enjoyed shopping for CD's and DVD's in local charity shops as an activity. Staff were clear that activities were scheduled for one person because they became anxious if their routine was changed. However, the other person receiving support was able to decide on activities at various points throughout the day depending on their mood and preferences. Examples of activities included; attending church, ten-pin bowling, bingo and meals out.

We saw from care records and promotional materials that the service recognised the need to adapt communications to meet the needs of individuals. Some records were produced using plain English and easy to read language which was supplemented by images to aid understanding. One person used basic signs to indicate their needs. While staff explained that another person preferred verbal explanations, but needed additional time to process the information and respond. The person's speech was sometimes difficult to understand, but the staff that we spoke with had learnt to interpret it effectively. In adapting its approaches in this way, the provider was meeting the Accessible Information Standard.

The service had a complaints policy that was readily available to people accessing the service and their families. There had been no complaints since the last inspection. The registered manager and service manager told us this was because the service had a focus on, "More informal processes and face to face meetings."

Neither of the people accessing support had any needs in relation to end of life care although we were assured that plans would be developed for anyone requiring this type of care in the future.

Good

Is the service well-led?

Our findings

At the time of the last inspection in November 2016 a registered manager was not in place which served to limit the rating under the well-led domain to Require Improvement. An experienced registered manager was subsequently appointed and was in post at the time of this inspection.

Relatives and staff spoke positively about the management of the service and the quality of communication. Comments included; "If I had any issues I would contact the team leader or the manager they are really good and I would have no hesitation contacting them", "They ask for my input, yes I am happy with that", "They let me know of any changes by email, notice boards and the daily book in the office. They are a good company to work for" and "The organisation communicates on a one to one basis. They are good at keeping me informed. I enjoy working for the company."

At the time of the inspection Natural Networks – Individualised Support Service was in the process of negotiating the transfer of its contracts to another service within the group. The strategy and vision for the transition were clearly understood and had been shared with people using the service, families and staff appropriately. The values of the service were consistent with others within the organisation and focussed on a person-centred culture which promoted people's rights and independence. This was evident in the promotional materials that we saw. The registered manager said, "We've had engagement days with staff. The transformation and change team are promoting the vision nationally."

The registered manager told us they were aware of the anxiety that the changes had generated and had taken measures to share important information and developments by way of re-assurance. The staff that we spoke with were aware of the changes and understood why they were being made. The registered manager relied on senior staff to relay information about day to day issues and we saw that this was done effectively through telephone calls and emails. Other information was shared the 'Quality Matters' newsletter which contained important information about; registration, risk assessment and events amongst other topics.

The registered manager was aware of their role and responsibilities both within the service and with regards to their registration. Notifications to the Commission had been submitted as required and the action plan arising from the last inspection had been completed in accordance with the agreed schedule. Ratings from the previous inspection were displayed as required.

The service maintained a full set of policies and procedures which clearly explained roles, responsibilities and expectations. The policies that we saw were sufficiently detailed and had been recently reviewed. Staff understood how to access policies if they needed to.

The service had a robust approach to the management of safety and quality. Regular audits were completed by staff and managers at all levels. A specialist quality team provided oversight of the processes and monitored completion. Key performance indicators were recorded electronically and used to rate services and produce action plans. We saw evidence that actions had been completed following audits. For example, in relation to; involvement in reviews, missing person's information and support plans. Critical information

and developments were shared across the service and partners to promote a culture of continuous improvement.

People using the service, their relatives and staff were engaged through regular meetings. Examples included; service user focus groups, management meetings and staff awards. The service also made use of social media to communicate and invite comment. One relative commented, "They ask for feedback once a year."

Although examples were limited because only two people were receiving support, we saw evidence of working effectively with partners for the benefit of people using the service. For example, staff attended reviews in a day service to ensure that information was shared and support plans aligned. We also saw that the service was working effectively with representatives of the local authority to ensure that reviews of commissioned hours were competed safely and sensitively in people's best-interests. We also received positive feedback from a commissioner regarding a change to medicines' administration that they recommended.