Independent Support Limited

The Willows

Inspection report

69-99 Greenbank Road
Tunstall
Stoke On Trent
Staffordshire
ST6 7EZ

Tel: 07599985191
Website: www.independent-support.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31 March 2016 and was unannounced. This was the first inspection for the service since they had registered with CQC.

The service provides accommodation and personal care for up to 12 people with a learning disability. The accommodation is provided in two units. In unit six there were six people all of whom had moved together from another service in October 2015. In unit eight there were four people who presented with more complex and challenging needs.

The service is required to have a Registered Manager. 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. There was a manager in post but they had not yet registered with CQC. They told us they were in the process of registering with us.

Staff did not always support people safely when they displayed episodes of behaviour that challenged. Not all staff had received training in this area and sometimes inappropriate manual handling techniques were used to manage people's behaviours which placed them at risk of harm.

People did not always receive their medicines as prescribed and medication errors were not investigated.

Staff did not always know how to support people safely when they displayed episodes of behaviour that challenged. Not all staff had received training in this area and sometimes inappropriate manual handling techniques were used to manage people's behaviours which placed them at risk of harm. Some staff had received the required training and the provider had plans in place to ensure all staff received the appropriate training so they would know how to handle people more safely.

There was a lack of contingency plans in place to deal with incidents and emergency situations. There was not always learning from incidents in order to make improvements where people's safety was compromised. The procedure for making safeguarding referrals had not always been followed.

People were supported to consent to decisions about their care and support and the provider adhered to the Mental Capacity Act 2005. People were supported to eat and drink and to maintain good health. Timely referrals to health care professionals were made when people's needs changed or they became unwell.

People told us they thought staff were kind and caring with them and it felt like a family atmosphere. We heard staff speaking with people in a respectful way and observed kind and caring interactions .

People did not always receive person centred care and support in the way this had been planned for them. It was not evident where or if people had achieved their goals. Staff supported people to include and involve

their family and friends in their lives. People knew how to raise concerns and knew these would be addressed. People had been supported well when they moved between services.

The quality of services provided was not effectively monitored in order to ensure people were receiving appropriate care and support and/or to drive through improvements. The manager was not yet registered with CQC. Staff felt supported by the manager and people and relatives told us the manager was supportive and approachable.

As a result of this inspection we identified two breaches of the health and Social Care Act 2008 as follows -

There was a breach of Regulation 12 - Safe Care and Treatment. There were not always enough staff provided with the right skills and experience to support people in a safe way. People did not always receive their medicines as prescribed and sometimes people's medicines were unavailable. Risks to people's health and safety were not reviewed regularly and risks were not always mitigated.

There was a breach of Regulation 18 of the Registration Regulations 2009 - Notification of Other Incidents. The provider had not always made referrals in respect of safeguarding incidents.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Not all staff had received appropriate training to keep people safe. There was a lack of contingency plans in place to deal with incidents and emergency situations. Incidents were not always recognised as safeguarding incidents and alerts were not always raised to appropriate professionals. There was not always learning from incidents in order to make improvements where people's safety was compromised. People did not always receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective. People were not always supported by a staff team with the right skills and experience to meet their needs. People were supported to consent to decisions about their care and support and the provider adhered to the Mental capacity Act 2205.People were supported to eat and drink and to maintain good heath

Is the service caring?

Good

The service was caring.

Staff knew people's likes, dislikes and preferences and supported people to make choices.

Staff had built good relationships with people and people felt like it was one big family.

People thought staff were kind and caring with them, had their best interests at heart and treated them with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. People who required one to one care and support did not receive person centred care and support in the way this had been planned for them. It was not evident where or if people had achieved their goals. Staff supported people to include and involve their family and friends in their lives. People knew how to raise concerns and knew these would be addressed. People had been supported well when they

moved between services.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The quality of services provided was not effectively monitored in order to ensure people were receiving appropriate care and support and/or to drive through improvements. Incidents were not always reported or referred as required and there was no evidence of questioning practice and learning from incidents. The manager was not yet registered with CQC. Staff felt supported by the manager and people and relatives told us the manager was supportive and approachable.

The Willows

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 31 March 2016 and was unannounced. The team consisted of two inspectors.

Prior to the inspection we reviewed the notifications we had received from and about the service. As a result of concerns we had received about the service we brought the inspection forward.

We spoke with eight people using the service and one relative. We spoke with five care staff members including two senior care staff and we spoke with the manager of the service. We observed the care and support four people received and looked at their care records including care plans, records of daily care and medication records.

We looked at records relating to the management of the service including monitoring of accidents/incidents, staff training and supervision, safeguarding and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received concerns that a person who used the service may not always be kept safe. There was one person with significant challenging behaviour needs. This person required two staff members to support them at times especially to participate in outings. We saw and staff told us that it was difficult to manage the person's challenging behaviour episodes and ensure other people were kept safe. One of these episodes had resulted in a safeguarding referral which was in the process of being investigated. There was sometimes not enough suitably trained staff provided to meet people's needs safely. For example, in unit eight there were four people with high dependency needs requiring one to one and sometimes two to one support. We saw and staff told us that there were four staff members on duty and there should be five on this unit. The manager explained that three staff members were currently off sick and that this was being managed and that some staff were able to pick up extra shifts in the unit. The manager came in to cover the shift, resulting in five members of staff in total. We saw that the provider had arranged for two staff with specialised training to monitor and observe the person with high dependency/challenging behaviour needs. These staff members were from the Local Authority Intensive Support Team. The manager asked the social worker for a referral to the team due to the individual's increased behaviours for advice and support on how the individual could be supported to keep them and others safe.

People did not always receive their medicines as prescribed. One person was unable to receive their medicine as it was out of stock. Discussions between the manager and the person's representative were on-going in a bid to try and resolve the medication issues. Another person had not received their medicine patch as prescribed and there was no documented reason for this. Medication errors were not routinely recorded as incidents and there was no documented learning from this. We saw that clear records were not always maintained in respect of the administration of peoples' medicines, which could easily result in errors being made by staff.

The provider had not always responded appropriately when people's safety was compromised. We saw that incidents had not always been referred to the relevant agencies as safeguarding incidents. The provider had not always reported when a person who used the service was physically aggressive towards another person who used the service. This had occurred on several occasions and there had been no recorded learning from these incidents. We had recently been made aware of a particular safeguarding incident from a whistle-blower. This incident involved concerns around how a person was moved and handled. The provider had not followed the correct safeguarding procedure and had not referred the incident to the appropriate local authority at the time. There had been some discussion around the incident with staff member at the time.

The whistle-blower had raised concerns that staff did not have the appropriate training to manage people whose behaviour challenged. They felt that people may not always be supported in a safe way. Records of how staff managed people's episodes of challenging behaviour suggested that sometimes inappropriate methods of manual handling may be being used inadvertently by staff who had not had the required training. Staff wanted to learn and told us they needed more training to ensure they "handling people properly". The provider had plans in place for all staff to undertake training in how to manage people whose behaviour challenged including using appropriate physical interventions. There was also plans for all staff to

complete safeguarding training.

Risk assessments had been developed based on people's specific needs but not everyone's individual needs had been taken into account. We asked staff about a person who had seizures and was at risk of harm during the seizures. We saw that there was no specific care plan in place for the episodes of seizures. The staff member who was looking after the person told us, "I'm not sure because I am not usually in this bungalow." Staff did not have any information about the person's risk of seizures and the person had been living in the home for several months. Risk assessments were out of date and had not been updated since October 2015.

The above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always met effectively because not all staff had the suitable training and skills. For example some people who used the service displayed behaviour that challenged. Not all staff had received up to date training in how to manage people with challenging behaviours and some staff had received no training in this area. This meant that people may be placed at risk of harm through lack of staff knowledge and skills. The manager told us and we saw that staff training updates were being arranged to increase staff knowledge and skills in both of these areas. The provider had a new mandatory staff training matrix in place to ensure staff would receive adequate training to meet people's needs.

We looked at staff recruitment and saw that new staff who did not have the required skills and experience were sometimes expected to work with people with high dependency needs without having the adequate skills and/or knowledge. We saw that two new staff members, one of whom had little experience of working with people with learning disabilities, and one who had no experience, had been placed to work in an area where people had behaviours that challenged. We saw that, during their supervision, one staff member had asked to be moved as they had found this setting too stressful for their first placement. We saw that the person had been moved to another unit. We spoke with the manager about this and they told us that they would review their recruitment procedures to ensure staff had the skills to meet people's needs.

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. We saw that people were given choices in relation to their daily care and support needs. For example we saw a person being offered choices about what to wear and what clothing to buy. We heard staff asking people what they would like to do next as an activity. For example a staff member said to a person, "Would you like to do another jigsaw [person's name] or something else?" The person said they wanted to do another jigsaw so this was provided for them. We saw that consent had been obtained from people and/or their representative throughout all the activities of their daily care and support plan.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some people had legally been deprived of their liberty and had authorisations in place. The manager showed us an example of how one person was "subject to constant supervision" and had a DoLS authorisation in place. This was the least restrictive option being used. This meant the provider was following the principles of the MCA and ensuring that people were not being unlawfully restricted of their liberty. When we spoke with staff they had a good understanding of mental capacity, consent and DoLS.

People had their nutritional needs assessed and were supported to eat and drink a well-balanced diet. People's health care needs were assessed and monitored and people were supported to attend visits to the GP and other health care professionals as required. When people's health needs changed and/or people

became unwell staff made timely referrals to relevant health care professionals. We saw that the provider had requested the help of health care professionals known as 'First Intensive Support Team'. They visited the home to help staff to support a person who had high dependency needs including challenging behaviour. They told us that staff were keen to learn and followed their advice.

Good

Is the service caring?

Our findings

People who used the service told us they thought staff were kind and caring. A person said, "The staff who look after me are good. They are all nice". We saw a staff member hug a person and ask them if they felt alright. The staff member explained that the person was upset as their hospital appointment had been cancelled due to them being unwell. The person smiled when the staff member hugged them. We saw a record for the previous night which was documented, "[Person's name] was upset tonight after their hospital appointment had been cancelled. I gave her a love then she went asleep and appeared to be asleep all night". The person later said her back was hurting and a staff member asked if she would like some pain killers. She said she would and the staff member gave the person the medication as prescribed. After this the staff member suggested the person relax on their bed for a while to feel more comfortable, which they did. This showed that staff were concerned about the people's wellbeing.

Staff understood people's needs and what they liked to do. A staff member explained what a person's interests were, "[Person's name] loves television, soaps in particular and making things". The person confirmed that they liked to do these things.

Staff helped to promote people's independence. We saw a staff member giving a person a drink and, referring to a drinks bottle, they said, "You hold it [Person's name]. Well done". The staff member used an appropriate drinks bottle to enable the person to drink independently.

We saw care records contained people's preferences, likes and dislikes and we saw that staff were aware of these and staff supported people in the way they wanted.

People's privacy and dignity were respected. An example of this was how we saw a staff member waiting outside a bathroom. The staff member said, "[Person's name] likes to shower themselves but shouts staff to help them with a shave". We heard the person shout and the staff member went in to assist. This helped to encourage the person to remain as independent as possible and also respected the person's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

People who had high dependency needs who required one or two staff members to support them directly (1 to 1) did not always receive the activities they had planned for them. We saw that a person should have participated in various activities on a one to one basis with a staff member but there was nothing documented for this person on several occasions (some mornings and some afternoons) over the three week period we looked at. We saw another person wanted to go out for a drive was told they could not do so because there was not enough staff to take them out. The person's care plan reflected this activity was planned in for them. The person became agitated and made a driving sign with their hands. A staff member said, "Later [Person's name]" and this made the person more agitated. The professionals First Intensive Support Team had advised/documented for staff not to say "Later" to the person but to say "After tea [Person's name], as [Person's name] has no concept of time". We observed staff did not adhere to this.

It was not always clear how the allocation of one to one time was utilised to help people. Some of the gaps where there were no activities documented was the time where people were down to receive one to one support for a particular activity. Staff told us it was difficult sometimes as there was not always enough staff available to ensure people's activities took place. They said some staff were off sick and some of the 'one to one' activities actually required two staff to support the person especially when going out.

For other people we saw documented and people told us that they were supported to participate in hobbies of their choice. A person liked swimming every week but said they hadn't been for a while because it was cold. Another person liked to have their nails manicured and they showed us their painted nails. People were participating in a jigsaw activity prior to lunch. Another person enjoyed photography and took pleasure in showing us their photographs. The person also had a grand collection of CDs and played some of their music for us.

People told us staff supported them to celebrate special events. A person who had recently celebrated their birthday said, "I had a good time it was a lovely party, my mum came".

People's needs and preferences were documented. People who were important to the person who used the service had been involved in developing the person's care/support plan. We saw where the family and college staff of a person had helped with their care plan. People had hospital passports showing their personal care preferences and needs. Care plans showed people's routines and preferences but had not been reviewed for several months and were out of date.

People knew that they could speak to someone if they had any concerns. A person told us, "If I wasn't happy about anything I could talk to [staff name] or [other staff name]. I have known [staff name] a long time." Staff knew how people reacted if they were unhappy and how people communicated their needs. A staff member said, "If [Person's name] isn't happy they spend more time in their room. Sometimes they just want to be alone or something might be bothering them and you need to talk to them about it". A relative we spoke with told us that when they raised a concern the manager and staff listened and acted on it. There was a

complaints procedure displayed so people who used the service could understand how they could talk to someone and raise any concerns they might have.

We saw, and people told us that, in unit six people had transferred from another service in October 2015. Six people had been supported in their new home and people told us how well the transfer had gone. A person said, "Its lovely here, I am with all my friends like I was before". The provider had ensured that all six people stayed together as they were previously and that the staff who had come to work for the service stayed with them. A relative said, "We were so pleased that [Person's name] could stay with their friends it was so important to them. They are like one big family".

Requires Improvement

Is the service well-led?

Our findings

There was a quality monitoring system in place but this required further development in order to be effective in driving through improvements. For example we saw that there were areas of medication that were unsafe and required auditing and improving. Where people had not received their medication as prescribed this had not been identified as incidents requiring improvement. Following the inspection the provider sent us copies of written medication guidance for staff in respect of a 'Homely Remedies Policy', a 'PRN Paracetamol Traffic System', and a 'How I like to take my medication' document.

There was no learning from events where people's safety had been compromised in respect of appropriate manual handling. For example we saw several examples of where people had displayed episodes of challenging behaviour, with one incident in particular with concerns that inappropriate manual handling techniques may have been used. There was no investigation into these incidents and/or no learning from them.

We saw care plans had not been updated since October 2015 so these may not have reflected people's current needs. Care plans contained people's short and long term goals but these had not been audited and reviewed for several months to ensure they reflected people's current goals.

The auditing and monitoring of how people received their one to one support was not taking place especially in respect of activities. This meant the provider could not be sure that people were engaging in activities of their choice. We saw people did not always receive the support to engage in activities which had been planned for them because this required one to one or two to one support and there was not always enough staff available for this.

Staff recruitment and training had not been managed to ensure that staff had the skills to meet people's needs. For example one staff member with no experience of caring for people with Learning Disability needs had been placed to work on unit 8. This unit accommodates people with high dependency needs including people whose behaviour challenges. This meant that situations arose which were unsafe for people and staff. Following the inspection the provider sent us copies of the new documentation being introduced for staff training. This consisted of a 'Compulsory Training Matrix' to monitor staff training in both units to improve staff knowledge. The provider had also arranged for all staff to attend safeguarding and challenging behaviour training in order to help develop staff knowledge and enable staff to support people more safely.

Safeguarding procedures had not always been followed in that incidents were not always raised as potential safeguarding incidents. For example there were several instances where a person who used the service had been physically aggressive towards another person but these incidents had not been reported. There was also an example of where a person had been inappropriately handled by a staff member and this had not been reported and/or referred as a safeguarding incident.

This is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18 Notification of other incidents.

There was no Registered Manager in place but the manager told us that they were in the process of applying to become Registered Manager. The manager was supported by senior care staff in each of the two units. Staff told us they felt supported by the manager and that the manager was accessible and approachable. The manager knew each person by name and was aware of their needs and preferences. They spent time in both units interacting with people and staff. Relatives told us they knew the manager and senior staff and could speak with them at any time.

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
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents 18(2)(e)The provider had not notified CQC of safeguarding incidents 18(4)(a) The provider had not notified CQC of a DoLS authorisation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for people who use the service. 12(2) (a) assessing the risks to the health and safety of people who use the service of receiving the care and treatment. 12(2) (b) doing all that is reasonably practicable to mitigate any such risks 12(2) (c) ensuring that persons providing care or treatment to people who use the service have the qualifications,competence,skills and experience to do so safely. 12(2) (g) the proper and safe management of medi