Next Steps Ltd

Next Steps Ltd

Inspection report

Office 10, The Lincoln Building
Eckland Lodge Business Park, Desborough Road
Market Harborough
LE16 8HB

Tel: 01536511833
Website: www.nextstepsuk.com

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08 March 2021

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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Next Steps is a domiciliary and supported living service providing personal care to nine people across seven properties at the time of the inspection. The service supports people with learning disabilities, autism, mental health and physical disabilities.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider and manager had not followed government guidance for the management of COVID-19 in relation to regular staff testing.

Staff had received training in infection control and demonstrated an understanding of what personal protective equipment (PPE) should be used when supporting people.

Quality monitoring systems needed strengthening to ensure that care plans and risk assessments contained all the required information for staff to follow to maintain people's safety.

Monitoring of people's daily records required improvement to ensure that staff are recording care provided as per people's care plans and risk assessments.

People were protected from abuse and relatives told us their loved ones received safe care.

People received support from a regular staff team and staff were recruited safely.

Staff were trained in administering medicines safely. Competency checks had been completed to ensure staff were following safe practices.

People's relatives spoke positively about the staff and felt people were encouraged to gain new skills and independence.

People were supported to remain in contact with their loved ones during the COVID-19 pandemic by phone calls, videos calls and social distanced meets.

Quality monitoring of accidents and incidents ensured that information and learning was shared with staff to reduce the risk of future occurrences.

We expect health and social care providers to guarantee autistic people and people with a learning disability

the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were the underpinning principles of Right support, right care, right culture. People's care was person centred and focussed on developing independence with recorded goals on how to achieve this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 09 March 2020).

Why we inspected
We received concerns in relation to the management of medicines and people's finances. We also received some concerns about staff training and management oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Next Steps Ltd on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Next Steps Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in seven 'supported living' settings, so that they can live 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.

The service did not have a manager registered with the Care Quality Commission. The provider had recruited a manager who had submitted an application to be registered. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 03 March 2021 and ended on 08 March 2021. We visited the office location on 03 March 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information

about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
Due to COVID-19 restrictions, we were unable to speak to people who used the service. However, we spoke to four relatives about people's experience of the care provided. We spoke with eight members of staff including the manager, team leaders and support workers.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies and procedures.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people were safe and protected from avoidable harm.

Preventing and controlling infection
- The provider had not implemented a regular COVID-19 testing programme for staff as per government guidance. This put people and staff at risk of contracting the virus. During the inspection, the manager implemented regular testing for staff following feedback from the Inspector.
- The provider had created videos to support people to understand how to protect themselves from COVID-19.
- Staff had received training in infection control and demonstrated an understanding of what personal protective equipment (PPE) should be used when supporting people. Relatives told us that staff wore the appropriate PPE when supporting people.

Assessing risk, safety monitoring and management
- People had risk assessments in place which supported them to take positive risks whilst maintaining their safety. For example, one person was being supported by staff to make friends with people they had met online.
- Staff understood the risks associated with people's care. However, we identified that further information was required in people's care plans and risk assessments to keep people safe. This was updated by the manager during the inspection.

Staffing and recruitment
- Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.
- People received support from a regular staff team including a team leader and support workers. Relatives spoke positively of the care and support provided by staff for their loved ones. One relative said, "[Staff] know [person] inside out." Another relative said, "[Team leader] is brilliant and dedicated. It's a really good team."

Using medicines safely
- Medicine administration records (MAR) were in place and people's medicines had been administered as prescribed. Where gaps of recording had been identified, action had been taken to address this.
- Staff had received training in administering medicines safely and competency checks had been completed to ensure staff were following safe practices.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were in place to protect people from abuse and relatives told us they felt their loved ones received safe care.

● The manager had made referrals to the local authority when required to protect people from harm.

● Staff received training on safeguarding and understood how to recognise and report abuse. One staff member said, "If someone was being abused financially, physically or mentally I would report it to [team leader] or [manager]."

Learning lessons when things go wrong

● Accidents and incidents were recorded including actions taken and were reviewed to identify trends or patterns to ensure lessons were learnt.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider and manager had not followed government guidance for the management of COVID-19 in relation to regular staff testing. This was implemented during the inspection and the provider's infection control policy was updated to reflect the change.
- Quality monitoring systems were in place which were comprehensive and regularly completed by the management team. However, we identified that these needed strengthening to ensure that care plans and risk assessments contained all the required information for staff to follow to maintain people's safety.
- Monitoring of people's daily records required improvement to ensure that staff are recording care provided as per people's care plans and risk assessments. For example, one person's care plan detailed they required their incontinence aids to be checked every two hours. However, staff had not recorded these had been checked every two hours and this had not been identified by the current quality auditing processes.
- Staff were open and honest during the inspection and changes were implemented following feedback from the inspector.
- The provider had employed a manager who at the time of inspection, had applied to become registered with CQC.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider and manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People's relatives spoke positively about the staff and felt people were encouraged to gain new skills and independence. People had personal goals recorded in their care plans that were reviewed monthly by staff with records of progression. One relative said, "[Person] has come on leaps and bounds. [Staff] encouraged [person] so much."
- Staff were encouraged to raise concerns about the care provided, including whistleblowing. Staff told us that they would feel confident raising any concerns or issues with the management team and that action

would be taken to address these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's relatives told us that they had regular contact with the manager, team leaders and support staff. People were supported to remain in contact with their loved ones during the COVID-19 pandemic by phone calls, videos calls and social distanced meets.

● Staff completed weekly 'keeping in touch' reports that were sent to people's relatives detailing activities taking part in and the person's reaction and response to these. One relative said, "I get reports all the time and it shows that [person] is happy."

● Regular staff meetings took place and staff told us that they felt involved and listened to. One staff member said, "The management team are really good. [Team leader] will help you with any problems and explains things so well."

● The provider was in the process of implementing quarterly quality meetings where people and their relatives will be invited to attend to provide feedback on the service.

Continuous learning and improving care; Working in partnership with others

● Quality monitoring of accidents and incidents ensured that information and learning was shared with staff to reduce the risk of future occurrences.

● Information was shared with other agencies where concerns had been identified, including CQC as required under the regulations.

● We saw evidence of partnership working with other agencies to develop the service provided to people including social workers and a community psychiatric nurse.