Tracs Limited

Wings

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 2 February 2017 and was unannounced.

The service is registered to provide care and support for up to six people with learning disabilities and conditions related to their mental health. At the time of our inspection six people were using the service.

There was a registered manager in post but they were on a period of extended leave, which they had previously notified us about, and the service was being managed by their deputy. 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.

Staff were trained in safeguarding people from the risk of abuse and systems were in place to protect people from all forms of abuse including financial. Staff understood their responsibilities to report any safeguarding concerns they may have. Appropriate action had been taken in response to safeguarding concerns.

Risks had been assessed and actions taken to try to reduce these risks.

Staffing levels matched the assessed safe levels. Recruitment procedures, designed to ensure that staff were suitable for this type of work, were robust and there was ongoing recruitment to fill current vacancies as a priority.

Medicines were administered safely and records related to medicines management were accurately completed.

Staff training was provided but some had not been appropriately updated, according to the provider's own schedule. Some relevant training related to the management of acquired brain injury, epilepsy and mental health had not been provided to all staff.

Staff had received training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS), although some staff had not had this for several years. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements. One application had been made to the local authority but locks and keycodes for the main doors meant that others were effectively being deprived of their liberty and the manager has since begun the process of assessing people's capacity to consent to this to ensure it is lawful.

People were supported with their eating and drinking needs and staff helped people to maintain good health by supporting them with their day to day healthcare needs.

Staff were very caring and treated people with kindness, making sure their dignity was maintained. Staff were positive about the job they did and enjoyed the relationships they had built with the people they were supporting and caring for.

People, and their relatives, were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Some care plans required further updating were in to reflect people's current needs.

People had opportunities to follow a range of outside interests and hobbies, although these were currently somewhat limited due to a lack of drivers for the service vehicle.

There was a complaints procedure in place but no formal complaints had been made. Informal concerns had been managed well.

Staff understood their roles and felt well supported by the acting manager.
Effective systems were in place to assess the quality and safety of the service and action had been taken to address any concerns. There was clear management oversight of the day to day running of the service. The manager had submitted all the required notifications regarding health and safety matters to CQC. Record keeping was acceptable, although some records needed further updating to reflect current needs.

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.

There were enough staff and recruitment systems were robust.

Systems were in place and staff were trained to safeguard people from abuse.

Risks were assessed and action taken to minimise these risk.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not all receive the training they needed to carry out their roles.

Staff had been trained in the MCA but the service had not followed legal requirements relating to the deprivation of people's liberty.

People were mostly well supported with their dietary and healthcare needs

Is the service caring?

Good

The service was caring.

Staff were patient, compassionate and kind and relationships between staff and the people they were supporting were good.

People had been involved in decisions about their care.

People were treated with respect and their dignity maintained

Is the service responsive?

Good

The service was responsive.

People, and their relatives, were involved in assessing and

planning care.

People's choices and preferences were recorded in their care plans and people followed their own interests and hobbies.

There was a complaints procedure but there had been no formal complaints.

Is the service well-led?

Good

The service was well led

The acting manager understood their role and responsibilities well.

The required notifications had been submitted to CQC regarding health and safety matters.

A clear system of quality and safety audits was in place.

Wings

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.

The inspection took place on 2 February 2016 and was unannounced.

The inspection team consisted of one inspector.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us.

We spoke with two people who used the service, one relative, three care staff and the acting manager. We also gathered feedback from Suffolk County Council adult protection team and from the learning disability team.

We reviewed four care plans, four medication records, two staff recruitment and induction files and staffing rotas for the weeks leading up to the inspection. We also reviewed quality and safety monitoring records and records relating to the maintenance of the service and equipment.

Good

Is the service safe?

Our findings

We found that staff knew how to spot the signs of abuse and take appropriate action. Staff had received training in safeguarding people from abuse, although some were overdue for a refresher, according to the service's training records. Staff were able to tell us what they would do if they suspected or witnessed abuse. They knew how to report issues within the service and directly to external agencies including the local authority and CQC. Information related to keeping people safe was clearly displayed at the service.

Safeguarding concerns at the service had been appropriately referred to the local authority and the service had co-operated with any investigations they has undertaken. Three complex safeguarding matters had arisen at the service since our last inspection and we saw that action plans were in place which set out how to keep people safe. Staff were able to tell us about these action plans in detail and were clear about how they would protect people from any potential harm. The provider had a behaviour specialist adviser, who had been called in to support staff after one particular incident. The service worked in partnership with other health professionals, including psychiatrists and the local adult protection team to help keep people safe from harm.

The service was responsible for keeping some people's money safe and had clear plans to do this whilst enabling people to be as independent as they could be. We checked balances for some monies held on behalf of people who used the service and found these tallied with the recorded balance and records were accurate.

We saw that risks associated with the general environment were well managed. There were clear processes in place to monitor the safety of the service and regular checks were conducted to ensure that the water temperatures did not pose a risk of scalding or of harbouring legionella bacteria. The fire equipment was regularly serviced and maintained and regular health and safety audits identified any possible issues and put actions in place to address them. Gas and electricity installations were appropriately tested and serviced. The service had a business continuity plan which contained clear guidance for staff on what to do in the event of an emergency such as an outbreak of an infectious disease or an event, such as a fire, which meant the people were not safe to stay at the service.

People's day to day activities such as, eating and drinking, bathing, travelling in a car and taking medicines had been assessed. Actions had been put in place to reduce risks as much as possible. We found that staff were clear about people's assessed risks, although some records required reviewing. One person's risk of developing a pressure sore had been assessed and a plan was in place to reposition them every six hours. It was not clear how this had been decided and staff were not noting down when they had repositioned the person which meant we could not be assured it was being done in accordance with the plan. They were also not being repositioned during the night. People who require repositioning need this over a 24 hour period in order to reduce the risk. The person did not currently have any pressure sores but staff were aware that their health had recently declined which would increase the risk. The acting manager assured us that this person's pressure care risk assessment would be reviewed.

One person had a risk assessment in place following a choke incident. This had been reviewed after an injury meant they were no longer able to overload their fork with too much food and so the risk was reduced. Once they had recovered from their injury staff were aware that their risk had increased and ensured they were monitored at mealtimes in case of further choking incidents.

People received care and support from staff who knew them very well. One relative told us, "There appear to be enough staff". A person who used the service was keen to tell us about all the activities the take part in and confirmed that staff are able to take them to these various places.

The service had a number of vacancies for staff and this had been an ongoing challenge. The acting manager told us that senior staff in the wider organisation had recently visited the service and now better appreciated the isolated geographical setting which added to the difficulty in recruiting new staff. The acting manager was positive about the additional they had received following this visit and was confident they would soon be able to recruit to the vacant posts.

Staff told us they felt there were enough staff on shift to meet people's needs and keep them safe. One staff member commented, "There's always enough staff. The agency [staff] are fantastic. We do have a set of people they send here first and they know us". Agency staff were used but there was always a permanent member of staff on shift. We looked at rotas and saw that staffing levels matched the service's assessed safe levels. A relative confirmed to us that they found the staffing adequate and had no concerns. When we inspected there were enough staff on duty to support people and keep them safe.

Management plans which had been put in place in order to keep people safe following two safeguarding concerns, involved monitoring where people were in the house. All the staff we spoke with were clear about this arrangement and told us that there were enough staff to ensure that this monitoring could take place effectively.

We reviewed staff files and found that the service had recruited people safely and carried out all appropriate checks, including one with the Disclosure and Barring Service (DBS), to ensure that staff were suitable and safe to work in this setting.

At our last inspection on 3 November 2016 we found that medicines were not being administered safely. We issues a requirement notice and the service provided us with an action plan outlining how they would make the required improvements. At this inspection we found a great improvement and medicines were administered safely. The service had switched to a new system of medicines administration in order to reduce the possibility of errors occurring and this had been successful.

There were systems in place for the safe ordering, storage, stocktaking, administration and disposal of medicines. We spoke with the member of staff who had a particular responsibility for medicines and found that they were extremely knowledgeable and competent. Medicines were stored in suitably locked cabinets and clearly organised. Staff had received training in administering medicines and this was refreshed annually. Before staff were deemed competent to administer medicines they were observed by senior staff on three separate occasions.

Medication administration record (MAR) charts had been fully completed and there were protocols in place for prescribed medicines which people took only occasionally (PRN). PRN protocols were clear and staff had signed to confirm they had read them. One member of staff was not entirely clear about how and when to give two epilepsy medicines, particularly if a seizure occurred outside of the service. We noted that the excellent PRN protocol was not routinely taken out with the medicines when the person was away from the

service. This meant staff would not be able to refer to the protocol for guidance. We fed this back to the manager and they assured us they would address this issue immediately.

Requires Improvement

Is the service effective?

Our findings

We saw that staff met people's needs in a skilled and competent manner which demonstrated that they knew the people well. We observed close relationships between the staff and the people they were supporting and caring for. One relative told us, "I am quite satisfied with the way the staff look after [my relative]". A healthcare professional told us that they found the staff both helpful and pleasant.

When staff first started working at the service they received a comprehensive induction and good support from the manager and acting manager. New staff spent time shadowing permanent staff and then began to work as a full member of the team. One staff member told us, "If a new person starts [the acting manager] brings them in and they shadow one of us. It's much better than it used to be". Newly employed staff were required to complete the Care Certificate. The Care Certificate directly relates to nationally recognised minimum standards that should be covered as part of any induction training for new care workers.

Training records showed that staff received training to help them carry out their roles and staff were positive about the training they received. Although a variety of training was provided we saw that specialist epilepsy training, training related to acquired brain injury and management of people's mental health conditions were not included, even though this was relevant to some people who used the service.

Some training had not been refreshed according to the provider's own training schedule. For example four people's emergency first aid training, which required retraining every three years, was overdue by more than a year for two people and for more than two years for one person. Similarly three staff members had not undertaken moving and handling training annually as the provider intended. One staff member had been due to have this training refreshed in 2013 making it more than three years since they last had training. Staff not having access to current best care practice in these areas places people at potential risk of harm.

The acting manager was aware that some training was long overdue and provided us with a schedule of training which they are intending to run over the next few months. They have also met with the provider's training manager to prioritise which training should be delivered first.

Staff told us they felt supported by the acting manager and we found that formal supervision sessions for permanent staff were held regularly and provided staff with a chance to raise issues as well as to receive feedback from their manager. Sessions were more frequent for new staff during their induction period. One staff member said, "I feel supported – absolutely. We have a really good team. An annual appraisal system was in place and staff were encouraged to develop their skills and take nationally recognised qualifications.

We noted that people's consent was established before care and treatment was provided. Staff had received training in the Mental Capacity Act (MCA) 2005 but some, including the acting manager, had not had this training for many years and we found that could be improved. Staff were clear about people having the right to make their own decisions on day to day matters such as how to spend their money and what to wear. Some decisions for people without the capacity to give their informed consent had been taken in people's best interests according to a structured process involving appropriate family members and adult social care

professionals.

However some decisions had been taken without the required MCA process being followed. For example one person told us that their relative was required to have their door open at all times so staff could check them for their own safety. This was not in the care plan that we viewed and warranted consideration of this person's capacity to consent to this as their relative implied to us they were not happy about this but had to follow the rules.

Similarly we saw that some measures had been put in place with the best intentions of keeping people safe. One person had bedrails in place but their capacity to consent to this had not been assessed and there was no record of any Best Interests decision taking place to establish if this was appropriate for them. The back gate, the main entry point to the service, was locked with a keycode and only one person who used the service had independent access to it. The acting manager commented, "It's locked for people's own safety. [People who use the service] have no road sense and there are potholes". The locking of the service in this way and the provision of bedrails constitute a restriction of people's liberty. Where a decision is taken to restrict people's liberty it must be carried out according to a structured process, which includes applying to the local authority to authorise the decision and which is governed by the Deprivation of Liberty Safeguards (DoLS) linked to the MCA.

Following our inspection the manager made immediate DoLS applications for some people who used the service and demonstrated an intention to ensure that all MCA processes were followed in future. They liaised with CQC and kept us informed of their actions. Further MCA, DoLS training is planned for this summer.

People who used the service were supported to eat a healthy and varied diet and were positive about the food. Staff provided sensitive support and encouragement to people who wanted to reach a healthy weight. Staff were knowledgeable about diabetes and supported people who had this condition to maintain a healthy diet. A large variety of foods, including vegetarian foods, were available and people who used the service were asked for their opinions about the food during their resident meetings. Foods were kept safely and dates of opened foods were recorded so that foods could be disposed of before they became unsafe to eat. People who used the service were encouraged to help with the preparation of meals as far as they were able and some had particular areas of responsibility.

Where people had been assessed as being at risk of not eating or drinking enough records of their food and fluid intake were kept. These documented an ideal amount of fluids the person should be encouraged to drink and we saw that this was mostly being met or exceeded.

We noted that one person's diet was lacking in variety. They had been losing weight and their general health had been declining. They had been referred to a dietician and to a speech and language therapist for advice and guidance and the service was managing the person's conflicting dietary needs well and looking to try to introduced some more varied pureed foods to encourage the person to eat. We noted that the person's health passport had not been updated to reflect their most current dietary needs. A health passport is a document that would accompany the person to any hospital visits or admissions to inform healthcare staff of important information about the person. We saw that this person and one other person did not have a recent record of their weight. The acting manager told us that the dietician was monitoring one person's weight but there were no records to confirm this.

People were supported with their healthcare needs and staff worked in partnership with a variety of physical and mental healthcare professionals, including neurologists, psychiatrists and district nurses to meet people's needs. Records confirmed that people attended dentist and optician appointments with the

support of the staff, however we found that two people's latest dental check-ups had been missed and not re-booked or any explanation given as to why they were missed. We also noted that charts to record one person's bowel movements had not been filled in on two occasions within the same week. The blank entries occurred within a run of several days where the person had no recorded bowel movement. This meant staff did not have an accurate picture of whether this person's bowel function was healthy. This could have signified a serious health problem which required urgent treatment.

We saw other examples of people receiving prompt medical treatment from GPs when an illness, such as a urinary tract infection, was suspected. For example concerns had been noted about one person's urine output and they had seen a GP and been prescribed antibiotics within 24 hours. This prompt treatment meant the infection was quickly brought under control.

Good

Is the service caring?

Our findings

People's independence was promoted and how they were treated with dignity, respect and compassion. We observed that people appeared happy with the way staff provided care and support. Staff demonstrated that they knew people very well and the atmosphere was caring and supportive. One staff member said, "I want to look after them like my family. [It's] how I would like people to look after my family. This is an amazing little home with really good people".

Staff were patient and gave people time to make their own decisions. A relative told us, "They're very patient with [my relative]. They have managed to calm [my relative] down quite a bit. I think they do very well".

Staff supported people in a relaxed way and were compassionate and kind and it was clear that relationships were good and people using the service trusted the staff and were comfortable with them. People were supported to make choices about how they spent their time and about matters affecting their day to day lives. One person was keen to show us their bedroom which had its own lock. It was important to them to be able to lock their possessions away and their own private space was respected.

People were supported to follow their own religious beliefs should they wish to do this.

People were involved in decisions about their care and support and had been involved in developing their care plans as far as they were able. Information was shared with people in a format that they understood and simple formats and pictures were used to make written materials more accessible. Where it was needed a communication chart was in place which helped to guide staff to interpret people's language and non-verbal signals.

People's views were respected. For example one person had stated that they did not wish staff to open their door and check on their wellbeing at night. The service had introduced an audio check instead which was much less intrusive but which could establish if the person was in any pain or distress.

The service did not regularly use an independent advocacy service but did communicate appropriately with relatives and involve them in decisions about people's care. One relative said, "They talk to me if they need to". Relatives were free to visit the service whenever they wished and we noted people popping in during our inspection visit.

Good

Is the service responsive?

Our findings

Each person had a care plan which was person centred and contained information staff needed to help guide them to offer the right support and care. Some information was not current and needed to be updated to reflect people's current needs. For example where one person's independence had increased some staff support had been reduced to a prompting role but their plan did not reflect this and recent care plan reviews had not identified this inconsistency. The acting manager was aware that some care plans and records needed to be updated and had already begun to tackle this.

Care plans were person centred and documented people's need. It was clear that the service was able to respond to particular changing needs. For example one person struggled to have an early morning shower every day and so thought had been given to changing this to a more suitable time. One person had recently begun to spend a greater part of their time in their bedroom and were often in bed. We saw that they had sensory stimulation including a light tube and music which they responded positively to.

Before being admitted to the service we saw that people's needs were assessed to ensure that they could be met. One recently admitted person had met with the acting manager on two occasions and had visited the service to meet the other residents. A care plan was in place and reflected likes and dislikes as well as goals and aspirations. We saw that as people changed their minds about their goals this was reflected in their care plans.

People spent their days in different ways and were supported to follow their own interests and hobbies as much as possible, although this was more of a challenge given the geographically isolated setting of the service and the lack of drivers for the service vehicle. The acting manager told us they were hoping to recruit drivers and were looking into the possibility of a volunteer driver. Annual holidays were provided for people who enjoyed this and we saw that plans were already being considered for a variety of holidays and days out for this year.

People had a timetable of events and activities and each had the opportunity to go out with staff each week and do their personal shopping. One person told us they went to a woodwork class which they enjoyed very much. They said, "I made a treat box for [another resident]. I love it there. I get paid". Other people had the opportunity to play golf, go to bingo, attend luncheon clubs, do board games and go out for meals. One person particularly liked lunch out and we saw from their daily records and receipts from their spending money that they did this on a regular basis.

Resident meetings were held to discuss a variety of matters and to receive feedback but these had not been held in recent months. Prior to our inspection the acting manager had identified this as an issue and had discussed it at the most recent staff meeting. They had put a plan in place to ensure that meetings took place regularly in the future. These meetings were documented on the weekly planner and staff we spoke with were aware of them and of their importance. Previous meetings had enabled people to ask about their leisure opportunities and suggestions about the provider had sought their opinions about the food.

People were consulted about the possible further development of the service. Some plans were being considered to extend the provision of the service and plans were in place regarding how people would be included in this process.

The service had an easy read complaints policy and complaints procedure in place. No formal complaints had been logged since our last inspection. Feedback was invited from residents as part of an informal process and staff were clear about when they would support people to make a formal complaint, should the matter be more serious. A new intranet system was being introduced and would give people the opportunity to log feedback and compliments on a live system for immediate consideration.

Good

Is the service well-led?

Our findings

People who used the service knew who the acting manager was and we saw that they acted as a role model for other staff. They were employed to give hands on care for two days a week which enabled them to have a good oversight of issues affecting the people who used the service and staff. Although this arrangement had clear benefits it was also evident that it was a challenge to ensure that all management responsibilities were carried out within the three days a week allotted management time.

Staff were very positive about the acting manager and told us they felt well supported. One person said, "Sam is very supportive. We have staff meetings every month and you can raise an issue if you want". Staff were consulted about the running of the service via an online survey. An additional survey to assess staff stress levels was planned for this year. The acting manager said that they in turn felt well supported and received regular visits from their line manager.

Staff meetings were held regularly and we saw that there were effective methods to communicate important information to staff including a 'read and understand' file which staff were required to check every time they came on shift.

The manager had kept CQC informed of significant matters relating to the health and welfare of people who used the service by submitting the required notifications. Although currently carrying out an acting manager role whilst the registered manager was on extended leave, they had a good understanding of their responsibilities. They also demonstrated a clear understanding of the challenges which faced the service and had identified recruitment as a priority and were considering organizing a job fair. Recruitment was difficult given the location of the service and the acting manager was trying to find creative solutions.

Records for people who used the service were mostly good but some updating was required to ensure they reflected people's most current needs. This had already been identified and remedial actions were underway. We found that staff records were well organised and comprehensive and all records were kept confidentially.

A good system of audits was in place which aimed to ensure the safety and quality of the service.
Staff carried out daily checks, such as water and fridge temperatures and these were reviewed by the manager. Audits covered the health and safety of the service and the provider carried out their own quality audit and had shared the findings of the last one, carried out in November 2016, with CQC prior to the inspection.

A medicines audit was carried out regularly and the acting manager had good oversight of medicines issues and had delegated responsibility appropriately to a staff member with experience of managing medicines at a senior level in another service. Spot checks on staff practice were carried out by the registered manager and acting manager. The most recent one had taken place in November 2016 during the night shift. We saw that the results were positive and the building had been found to be secure and staff had been carrying out their required duties. Other regular observations of staff practice were in place such as observing staff

administering medicines and supporting people with their money.