Community Integrated Care

Wakefield Regional office

Inspection report

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Date of inspection visit:
27 March 2018
29 March 2018
18 April 2018

Date of publication:
12 June 2018

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 comprehensive inspection took place on 27, 29 March and 18 April 2018 and was announced on each day. This was the first inspection of the service at the current registered location.

This service provides care and support to people living in 17 '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.

Wakefield Regional Office provides a supported living service for people with a learning disability, some of whom have additional disabilities. Each supported living home is situated in a residential area, within walking distance of shops and local amenities. The homes are located around Pontefract, Wakefield and Castleford and accommodate between two to five people.

There was a registered manager in place. 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.

People received good care and support and they were encouraged to lead lives in line with their own preferences and choices. The emphasis was on supporting people to be as independent as possible. People were involved in making decisions about their care and how the service was run.

Care and support plans contained clear and up to date information and were person-centred. There was clear and specific information about how to support people with personal care, whilst promoting dignity and respect.

People were supported in having their day to day health needs met. Health services such as dentists, doctors and opticians were used as required and there were close links with other services such as the local Community Learning Disability Team.

Staff were knowledgeable about the needs of each person and how they preferred to live their lives. Staff received the training they needed and were supported through regular supervision meetings with a manager. There were safe recruitment practices in place for new staff and there were a sufficient number of staff on duty to meet people's needs.

There were robust systems in place to keep people safe. Staff were confident about their responsibilities in relation to safeguarding and also knew who they could contact regarding any concerns they had about the service.

There was a positive approach to risk taking so that people could be as independent as possible. Risks in peoples' day to day lives had been identified and measures put in place to keep people safe. The focus was on how each person benefited from the activity undertaken.

Supported living homes were suitable for the people who used the service. Checks and tests were carried out regularly to make sure the environment was safe.

The legislative requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed.

Staff told us that the service was well managed and that the provider was involved with the service. The registered manager promoted a culture of respect, involvement and independence. There were good systems in place to make sure that the quality of care was maintained. Areas that required improvement were identified and necessary action taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe at the service. Staff had a clear understanding of their safeguarding responsibilities.

There were good systems in place to protect people from the risks associated with care and support, day to day activities and the environment.

There were sufficient numbers of staff on duty to keep people safe. Staff had been recruited in line with safe recruitment practices.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received the support they needed to carry out their roles effectively. The staff team had a good understanding of the needs of each person at the service.

Relevant legislation and guidance was followed where people were unable to consent to decisions about their care and support.

People received the support they needed to stay healthy.

People were able to decide what they wanted to eat and told us that they enjoyed the food and drink provided.

Is the service caring?

Good

The service was caring.

People had good relationships with staff and were treated with kindness and respect.

People were encouraged to express their opinions and make their own decisions about care and support. People were

encouraged to be independent and were supported to spend time in the way they wanted.

Is the service responsive?

Good

The service was responsive.

People were involved in contributing to how their care and support was provided. Individual preferences were taken into account and people were supported to take part in activities of their choosing.

The staff team knew people well and could identify if someone was unhappy. Appropriate action was taken if a concern or complaint was raised.

People at the end of their lives were supported with compassion and dignity.

Is the service well-led?

Good

The service was well-led.

There was effective management of the service and a clear culture which promoted involvement and community participation.

The registered manager had good oversight of the service. Staff told us that they felt supported by management.

There were effective systems in place to make sure that the service continued to deliver good quality care.

Wakefield Regional office

Detailed findings

Background to this inspection

Inspection site visit activity took place between 27 March and 18 April 2018. We gave the provider 48 hours' notice of the inspection. This was because we needed to make arrangements to meet with people and staff and visit a house. We visited the office location on 27 March 2018, to see the manager and review governance records. The inspection team was made up of one adult social care inspector. We met with groups of staff and people who used the service on 29 March 2018 and visited a house, to meet people and staff, and review records, on 18 April 2018.

This was the first inspection of the service at this registered location.

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 was 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.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sought feedback from the local contracting authority.

During this inspection we visited the office on the first day to discuss governance and meet with the registered manager and two locality managers. On the second day we had group meetings with 19 people who used the service and 16 members of staff in different care roles. On the third day we visited a house and spoke with the staff and people who were present. We looked at records which related to people's individual care. We looked at three people's care planning documentation and other records associated with running the service. This included, training records, staff files, the staff rota, audits, medicine records and records of meetings.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe. Feedback included, "It's safe" and "I feel safe". Staff raised no concerns about the safety of people they supported.

We looked at how the service protected people from harm or abuse. There was a safeguarding policy in place which was kept up to date. Staff confirmed they had received training in safeguarding and knew what action to take if they had any concerns. Safeguarding was a regular topic at team meetings and was discussed with people to promote their personal safety. People were given an easy read guide to keeping safe. This gave information about what people could do if they felt concerned about something.

There was a clear record of any accidents or incidents which occurred at the service. Records included a statement from staff as well as any follow up action. Consideration was given as to whether the local safeguarding authority needed to be informed or if an accident was reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences regulations.

Any accidents or incidents were recorded on an 'event tracker' form. The tracker gave a detailed overview of incidents and identified any concerning trends, either service-wide or specific to each house. Where concerns were identified, action was taken, such as the provision of extra support for a person due to their behaviour.

Safeguarding alerts and serious accidents and incidents had been notified to the correct authorities, including the CQC when necessary.

Risks associated with people's day to day lives had been identified and there were clear, up to date risk assessments in place. These included risks associated with bathing, behaviour and moving and handling. There was a positive approach to risk taking, with the emphasis being on encouraging independence and community participation. Risk assessments included information about how to minimise each risk and what the consequence would be of the risk occurring. This meant staff had information about how to keep people safe, whether inside or outside the service.

Each person had a Personal Emergency Evacuation Plan (PEEP) which detailed clearly how they should be supported in an emergency. The information included guidance for staff about how an emergency evacuation may affect each individual and their behaviour.

There were systems in place to make sure only suitable staff were employed to work with people who used the service. Checks included two references, proof of identification and a background check through the disclosure and barring service (DBS). The DBS check helps employers make safe recruitment decisions. We noted that all references were sent to the manager for review, before a recruitment decision was made. Applicants were invited to 'meet and great' sessions at people's homes, which were also used to assess their suitability.

Each house had a dedicated core staff team which meant people had support from familiar workers who understood their needs. Through our observations and feedback from people and staff, we found that staffing numbers were sufficient to meet people's needs. When we met with a group of staff, none of them raised issues about staffing levels. One member of staff commented, "I feel there are sufficient numbers of staff. Teams stay with the same house generally".

There were safe systems for the storage and administration of people's medicines. The majority of medicines were stored in locked cabinets in people's rooms. The Medicine Administration Records (MARs) we looked at were easy to understand and properly completed. They included a picture of each tablet, which assisted staff in making sure the correct medicine was administered. A record was kept of medicines no longer used and which had been returned to the pharmacist. Each person had their own medicines folder which gave an overview of their medicines as well as why they were taken. Any special instructions for administration were made clear, as well as any allergies or side effects.

There was information about the use of 'as required' (PRN) medicines, such as pain relief. When these had been administered, a description of why it had been needed was recorded on the MAR. This helped staff identify if a medicine was effective or being over-used. PRN protocols were in place, which gave guidance about their use and when they may be required. Staff confirmed that they were only able to administer medicines after being trained and then being approved by a manager.

Robust checks took place on the safety of the environment. There were up to date risk assessments in place for environmental hazards and fire safety. Each house carried out weekly health and safety checks to make sure the environment was safe. Staff told us they worked closely with housing associations and landlords were responsive to requests for repairs.

There was a fire risk assessment in place and there were regular checks on the fire system to make sure it operated effectively. Each house held records of up to date test certificates for gas safety and electrical wiring. Any equipment, such as a hoist, was regularly checked to make sure it was safe to use. We noted there were useful guides for staff in people's care plans to show how the equipment should be used safely. This included photographs, as well as clear, step by step information.

We identified no issues with regard to infection control and cleanliness. The house we visited was visibly clean, free from clutter and well maintained. Staff had access to personal protective equipment such as gloves and aprons, if needed.

Good

Is the service effective?

Our findings

Staff told us they liked their work and felt supported. Comments included, "I enjoy the job. We do it because we enjoy it. It's very rewarding." and "We have supervision and appraisal where we you can air your views and say how you feel. We talk about career progression". One staff member who has dyslexia told us they were supported with equipment to assist them in reading and writing.

Staff received appropriate supervision and support to carry out their roles effectively. 'You can' supervision booklets were used to record discussions and agreed actions. This contained forms for recording supervisions throughout the year. Annual objectives for staff were also recorded on the form which included key behaviours, making a positive difference and personal development. These objectives were reviewed at each supervision to assess progress. The booklet was a useful document which enabled staff and supervisors to quickly review past discussions and progress.

Staff told us they got the training they needed to support people effectively. Feedback included, "Training is improving. There is more focus on person-centred care" and "We get lots of training".

Staff demonstrated a good understanding of areas of practice in which they had been trained. Training records showed that staff were trained in key areas of practice such as manual handling, safeguarding and medicines. Where people had particular needs, such as with hoisting or eating, staff were trained specifically in how to support them, by skilled professionals. Training was kept up to date and monitored by seniors.

People provided positive feedback about the staff who supported them. Comments included, "Staff are very nice. I like the staff here", "Staff help. Staff are nice. I can talk to them" and "I like the staff". We observed that there were good relationships between care staff and people who used the service. The staff we spoke with were well informed about the people they supported and had a clear understanding of each person'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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of this legislation. There was clear information in people's records about their capacity to make decisions. This included details of how individuals made decisions and how staff should ask questions. A mental capacity summary sheet explained why a person was found to lack capacity for any particular decision. Where there were any restrictions on people's liberty, such as being unable to go out independently, the appropriate authorisation was in place. Any restrictions were noted, together with information about how this impacted on their daily life.

Evidence was kept in support plans where any relative or friend held legal authority to make decisions on

someone's behalf, such as Enduring Power of Attorney.

Best interest meetings had been held where necessary. A best interest meeting is attended by those who know the person well, such as relatives or professionals involved in their care. A decision is then made based on what is felt to be in the best interest of the person. We saw examples of best interest decisions being made for accommodation and personal care, medicines and finances.

The manager and staff we spoke with were aware of the requirements of the MCA and records showed that the staff had received training in this area.

People were supported to maintain good health. Each person had a Health Action Plan which gave details about health needs and how these were to be met. Care records showed there were good links with health professionals to support people when needed. These included the community learning disability team, dentist, GP and chiropodist. Each person had a 'hospital passport' which gave essential information for hospital staff, should they be admitted in an emergency.

People told us they were provided with a range of food and drink, which they enjoyed. People decided on a menu each week and helped with the weekly shopping. Meals were usually cooked by staff, with the assistance of people who used the service. One person told us, "I'm a good cook" and another commented, "Staff cook good dinners".

For people who required support with eating and drinking there was clear information about their needs in care plans. This included likes, dislikes and allergies, as well as any support needed to eat properly and maintain their weight. Where appropriate, referrals had been made to professionals, such as the speech and language therapy team, to provide additional support and guidance.

One member of staff told us, "If people need support with eating we get help from a dietician. We have training on dysphagia (difficulty with swallowing)". They talked about supporting one person to take food through a tube into the stomach and explained, "The team are confident about this. We are all trained".

Good

Is the service caring?

Our findings

People told us they were happy and enjoyed living in their homes. Comments included, "I like it" and "Staff are very nice".

Throughout the inspection we observed staff spoke with people in a friendly manner, listened to what was being said and responded in a way that was understood and relevant to the person. The impression given was of a service that was centred around the people that lived there and what they wanted to do. The atmosphere during our meeting with people was light hearted, relaxed and fun. It was clear that people had positive relationships with the staff supporting them.

The staff we spoke with described a caring service. A staff member explained, "Everyone wants to give people as much as possible. You need to care. Advocate on behalf of people. We know people inside out. We know if something is wrong. We fight for them. Everyone is unique". Another member of care staff told us, "Would I want to put a family member here? Yes!"

Staff described an example of how they cared for people. One person is living with dementia and used to enjoy going to the beach. Because the person lacked mobility, staff decided to bring the beach to them, including sand and seaside items. They said this had been a good way of triggering memories in a fun setting.

Staff told us that dignity was strongly promoted by the organisation. A member of care staff said, "Dignity and respect is part of induction, for example, treating it as people's home, not a workplace. Everyone has their own front door key and a lockable safe in their room. Relatives can visit when they like". We noted that when we arrived at houses, the door was opened by people who lived there which showed staff respected it was their home.

There was a strong emphasis on respect within the organisation. One of the core values was, 'Respecting, considering and consulting with our customers'. We noted that people were provided with easy to understand information about their rights, in the service user guide. This included the right to respect, privacy and dignity as well as the right to confidentiality.

During the meeting we noted that staff made sure those people who could not participate verbally, had opportunities to express their views and were included. For example, one person was deaf and their support worker promoted respect for this individual by making sure they had a say and were not left out.

Support plans included information about diversity and any needs in relation to this. One person who is visually impaired told us care staff supported him by regularly describing what was happening around him. Support plans included detailed information about how best to communicate with people. This included the use of body language or particular phrases. There was a section which explained what the person might say, what this meant, and what they might want. There was also detailed step by step guidance on people's daily routines and how people liked to do things. This meant staff had the information they needed to

involve people as much as possible.

People were supported to be independent and be involved with day to day decisions about what they wanted to do. The daily routine was led by people's choices, for example, to go out or stay at home, and staff respected this. Some people had specific independence plans, such as learning how to wash the laundry. This was broken down into small, achievable steps, for example, putting the clothes in a basket. People confirmed they were given choices and one person told us, "I had my bedroom decorated. I chose the colour. Like a jungle. I chose the wallpaper".

Where required, people had access to advocacy support. An advocate is someone who is independent from the service and who helps people to speak up for themselves.

Good

Is the service responsive?

Our findings

People received person centred care which was responsive to their needs.

A new filing system had recently been introduced that made sure support plans were completed consistently and with relevant information in the same sections. This meant staff who worked in different houses were familiar with how support plans were structured.

Support plans contained detailed information about preferences and approaches for making sure individual needs were met. A one page profile gave a summary of what was important to each person, how they wanted to be supported and what others admired about them. There was a section for putting any preferences for support staff. One person had recorded they wanted a consistent team with a good sense of humour. This had been provided for them.

Support plans included a summary of 'My life so far' with details about health, education and relationships. This gave a useful overview of their character and background. Information about daily routines, including support with personal care was person-centred and specific in detail. For example, one person's 'How I start my day' support plan gave good details of their routines and preferences, such as, 'Put a small amount of toothpaste on brush and rub into the bristles, otherwise [Name] washes it off under the water'.

People had formal reviews every six months to make sure care and support reflected their current needs. Progress against identified goals was discussed and an action plan set up for meeting new goals and supporting with any issues. Each person also had a regular meeting with a keyworker where they talked about how they were getting on. A staff member told us, "We have a support plan amendment form. Support plans are continuously updated when we identify changes".

People were involved in support plans and reviews wherever possible, although the level of participation was dependent on each person's understanding. Staff told us that reviews considered each person's communication needs and what support they might need to participate, such as the use of pictures.

People were supported to take part in age appropriate activities and follow their interests. The people we spoke with talked about what they did during the week. Comments included, "I go to the bank", "I have a boyfriend" and "I go out on a bus. To luncheon club and coffee mornings". Other activities included going to shows and pantomimes. One person said they had wifi in their house and added, "I have a tablet". There was a culture of helping people achieve what they wanted. For example, one person wanted to buy a tree house for the garden and this was being arranged.

Some people were able to go out independently, although most people required some support to go into the community. People who required support told us they were usually able to go out when they wanted. We noted there were plenty of opportunities for people to involve themselves in the local community and transport was available.

Support plans included detailed information about people's interests and the support they required to participate in them. Reviews were also used to evaluate how activities were going and if there were any other things they wanted to do.

Complaints had been investigated and responded to appropriately. A record of complaints and compliments received was held in the main office. All complaints were monitored by the quality team, to make sure they were acted on in line with policy. Complaints were discussed in team meetings in order to review actions and consider learning actions. A comprehensive complaints procedure was in place which gave information about how complaints should be managed and timescales for response and investigation.

People told us if they had any concerns or were unhappy, they would talk to a member of staff. An easy to understand complaints leaflet was given to people and Keyworker meetings were used as an additional way of checking if people had any problems.

The service occasionally supported people at the end of their lives. One staff member talked about a person their team was currently supporting. They explained, "We worked through their end of life plan with them. Liaised with the end of life team for support. We also supported other people in the house to help them understand. The staff member added, "We have got a headstone. He wants a horse and carriage for the funeral and seniors have supported this. He has decided on the flowers. Everything is ready for him". This demonstrated an inclusive and caring approach to supporting people at this sensitive time. Another member of staff told us, "We have the palliative team and district nurse coming in. We are managing okay as a team. There is a counselling hotline for staff if we need to talk".

Good

Is the service well-led?

Our findings

We asked people what rating they would give the service. Everyone said 'Good' or 'Excellent'.

There was a registered manager in place. 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.

The manager registered with the CQC during the course of the inspection. They had been managing the service for a year. They told us, "I'm finding it alright. I have support from the company. I can ring anybody in senior management. My line manager is the regional director who visits all the services. We meet at least monthly". They added, "I have had 20 plus years in social care. My passion is people. Being there for people and getting it right for them. Giving them a voice and the best possible care. I like to share my experience and knowledge".

The staff we spoke with gave positive feedback about the management. A locality manager told us, "I'm supported through [registered manager name]. We can speak whenever we want. She is incredibly supportive. We have lots of informal chats".

There were processes in place to make sure that the quality of the service was monitored and action taken where improvements were required. The registered manager and senior staff carried out a range of checks and audits to make sure standards were maintained. These included weekly audits on records as well as monthly visits to each house by the manager.

The provider had introduced a new system for monitoring services and internal audits were carried out by a quality team. The registered manager explained, "The quality team send out a monthly report overview. They even audit my audit files!".

A continuous improvement file was maintained by the registered manager. This included an annual improvement plan which was completed with service leaders and reviewed monthly. There was a matrix which provided an overview of the yearly quality assurance cycle. We noted this was completed in line with CQC's five domains of safe, effective, caring, responsive and well-led.

The registered manager talked about some of the current improvements taking place and explained, "We are improving communication with staff. Encouraging team work. Our focus is more person-centred". This was confirmed by a service manager who told us, "The company is listening more. Over the last year the company is much more person focussed and valuing of staff. There is better involvement. They are introducing more structured systems. I know what the company expects of me. Seniors are more empowered and systems more effective". Another service manager told us, "The organisation is stepping in right direction".

There was evidence that the service worked closely in partnership with other agencies to support people to stay safe and lead fulfilling lives. These included, the local community learning disability team, health services and voluntary groups.

Staff were actively involved in shaping the service and were able to contribute ideas and suggestions about organisational practice. One member of staff talked about 'Game Changers'. This was a regular forum for the provider to discuss ideas and suggestions with staff representatives. There were also regular team meetings where staff could share ideas and discuss practice issues.

The staff we spoke with were aware of the values and ethos of the organisation and that a mission statement was displayed on the provider's website.

Annual surveys were sent out to people who used the service, stakeholders and staff. These gave interested parties an opportunity to feedback their views about the service. The registered manager explained that surveys were returned to Head Office and a summary of the feedback was sent to them for review. In addition to the surveys, people were encouraged to contribute their opinions and ideas through the monthly keyworker meetings and house meetings. The registered manager told us a regional forum for people who used the service was being set up as a more formal way of involving people.