Northern Life Care Limited

UBU - Harrogate

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
This service provides care and support to people living in their own homes. The Harrogate office is the headquarters for support provided across the North East, East Midlands, the North West, and Yorkshire. People are supported in single occupancy houses, shared houses in multi occupancy or in individual flats in larger complexes. Not everyone using UBU – Harrogate receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection 416 people were using the service. 143 people of who were receiving a regulated service.

People's experience of using this service
The principles and values of Registering the Right Support other best practice guidance ensure people with a learning disability and or autism who use a service can live as full a life as possible and achieve the best outcomes that include control, choice and independence. At this inspection the provider had ensured they were applied.

The outcomes for people using the service reflected the principles and values of Registering the Right Support in the following ways. People's care needs were holistically assessed, and care was mostly provided in line with current best practice guidance. Some relatives thought there could be a more consistent staff approach to enhance people's quality of care. We have made a recommendation regarding the management of some medicines.

Staff worked together to provide people with seamless care when they accessed services and moved between services. Most people had support, which clearly focused on them having as many opportunities as possible to gain new skills and become more independent. They were supported to follow their interests and pursuits including in the wider community and accessed education and work opportunities. Relatives told us people with more complex health care needs did not always have the opportunities they would wish.

People were encouraged to develop and maintain relationships both within the service, with family and loved ones, and in the community. There were some inconsistencies about care delivery and the ability of staff to evidence effective, sustained improvements in some cases. We have made a recommendation regarding the management of complaints.

The provider and management had completed a range of monitoring visits and audits. When these had identified issues, action had been taken to resolve them. They had strong values of improving people's support and providing high quality care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Many people

using the service lacked capacity to make specific decisions and there were appropriate systems in place to make them. People had care plans which were personalised and provided a wealth of information for staff to use to support their needs and wishes.

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

Rating at last inspection
At the last inspection the service was rated Good (report published 14 October 2016).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, 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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

UBU - Harrogate

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
A team of eight inspectors carried out the inspection.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

This service provides care and support for people in 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We informed the provider of our visit on 25 March 2019 because some of the people using it could not consent to a home visit from an inspector, which meant that we had to arrange for a 'best interests' decision about this. We gave notice of the inspection on 25 March and information including easy read documentation has been forwarded to them. We sent the registered manager information about the inspection and questionnaires in an easy read format to gain people's views.

Inspection site visit activity started on 3 April 2019 and ended on 18 April 2019. Two inspectors visited the agency office on 3 and 4 April. Seven inspectors carried out visits to supported living services.

What we did before the inspection
We reviewed information we received about the service from the provider since the last inspection, such as safeguarding notifications. We sought feedback from the local authorities and professionals who worked with the service. We looked at feedback from a fire safety prevention officer. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with the registered manager, chief executive officer and nominated individual, together with managers responsible for quality compliance, training, and the clinical team. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We held a focus group at which 20 staff attended.

We carried out observations during visits to each of the 12 supported living settings we visited. We spoke with people, managers and staff including area managers, regional development managers, scheme managers and support staff. We had more informal interactions with people who had limited verbal communication. We spoke with relatives on the telephone or in person during and after the inspection. We spoke with 12 relatives in total.

We reviewed a range of records. This included 12 people's care records and associated medicine records. We looked at four staff files in relation to recruitment, supervision and training. Multiple records relating to the management of the service and policies and procedures were reviewed during and after the inspection. We observed care and support in communal areas. We looked at staff files, information received from the provider, staff rotas, quality assurance audits, staff training records, the complaints and compliments system and medication records.

After the inspection
We looked at information the provider sent us regarding complaints and safeguarding data and feedback from people using services, relatives and staff. We spoke with five professionals who are involved with people receiving a regulated care service to gain their views.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Staff demonstrated a good understanding how to recognise potential abuse and keep people safe. Safety issues were reinforced through staff supervision, at meetings and in regular tenant and partnership forums. One staff said, "Everyone is safe, we work really hard to ensure that."
- Staff knew people well including how they communicated if they were unhappy or upset. This was important as some people had minimal verbal communication.
- Relatives thought their family members were safe. Although appropriately investigated relatives told us local staff did not always keep them fully informed about improvements they planned to make.
- Local authority safeguarding teams told us safeguarding issues were always reported; staff knew who to report concerns to and they said managers acted promptly to concerns.

Assessing risk, safety monitoring and management

- Care plans detailed the care and support people needed to keep safe. Risks were assessed and suitable plans to reduce these were mostly in place. For example, risks to people's skin integrity were recorded and healthcare advice and support sought. Information was not always updated in a timely way. For example, regarding risks associated with smoking for one person. During the inspection a regional manager acted to rectify this.
- Positive behaviour plans were developed to guide staff on de-escalation and distraction techniques to reduce people's anxiety and distress safely and consistently.

Staffing and recruitment

- Staff were deployed in line with people's contracted hours. During our visits we found people's needs were met and environments were generally calm; no one was seen waiting for long when they needed support.
- Staff were mainly positive about the level of staffing. One said, "[Managers] are quick to respond if anything is raised."
- Some relatives were concerned about frequent staff changes. They believed important information may have been lost with the staff who left, which impacted care. One relative said, "Staff are lovely people, but it's not the same here now." Other relatives thought their family members went out less or did not have the same quality support they had enjoyed previously.
- The registered manager was very aware of where all the highest needs were. They acknowledged how unsettling changes could be and described how they tried to minimise the impact of these. For example, by using familiar agency staff to ensure consistency.
- Effective and robust recruitment processes were followed to ensure only suitable staff were employed.
- The registered manager visited agencies to check their records to ensure agency staff were appropriately recruited and trained. Agency staff had the opportunity to read the relevant profiles and support plan for the

specific person they were supporting.
Using medicines safely
● Staff knew how to administer medicines in line with their assessed care needs. For example, medicines for one person were disguised to ensure their compliance (we sometimes call this covert administration). The person had experienced reduced seizure activity and improved health and wellbeing.
● Although we found people received their medicines safely and in a timely way medicines management was not always consistent with best practice guidance. Protocols for medicines administered 'when required' were brief and did not always fully support staff. Information regarding anti-anxiety medicines for another person did not fully match their behaviour plan. An area manager acted to rectify this and ensure it fully reflected the person's needs.

We recommend the provider considers current guidance on medicines administration and storage and act to update their practice accordingly.

Preventing and controlling infection
● Staff received training in keeping people safe from the risk of cross infection. They were able to describe how they used protective equipment such as gloves and aprons to keep people safe. Each home had a cleaning rota and people were supported to maintain their own bedrooms.

Learning lessons when things go wrong
● The provider was proactive about learning lessons and improving the service. All staff and management were aware of these values. One staff said, "It's really supportive if you make a mistake it is all about learning. managers are really supportive." Examples were seen of how this approach had been applied in practice.
● Accidents and incidents were logged on to an electronic system, which staff and managers accessed. Senior managers monitored patterns and trends and action taken to prevent recurrence.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

There was an improvement in overall effectiveness to good. Some feedback raised concerns about practice and about staff adhering to policies and procedures.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection we recommended that the provider consider current guidance on the specialist needs of people who use mental health services. The provider had made improvements.
● People's physical, mental and social needs were assessed; care and support were delivered in line with legislation, standards and evidence-based practice.
● Care plans reflected regular reviews; they contained relevant, up to date information including protected characteristics under the Equality Act. Staff spoke about respecting difference and treating people with equality of opportunity; they knew to challenge discrimination when out in the community or receiving other services.
● Staff knew to contact appropriate specialists to reassess a person when needed. For example, one person was getting a new bed due to concerns over skin integrity. There were occasions when staff action was not timely; two relatives told us they had intervened to ensure appropriate referrals were made and action was taken. People's records were not always clear in this regard. We discussed this with an area manager who agreed to follow this up as a training issue with staff.

Staff support: induction, training, skills and experience
● People received care and support from staff who were well trained. One told us, "Training is excellent." Staff were alerted to refresher training through 'my diary' alerts electronically; the provider did not permit staff to work unless training was fully up to date.
● Staff maintained their skills in line with best practice guidance; they undertook current health and social care training. When specialist training was required for individual people, the management of the supported living service liaised with other professionals such as epilepsy nurses.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink a healthy, balanced diet in line with their needs and wishes; diets were designed around people's specialist health needs and advice. For example, from speech and language therapy teams or diabetes nurses.
● People had access to a range of food. Once a week people discussed their menu plans for the coming week using pictures to assist choices. Once agreed staff supported people to do their food shopping and meal preparation where possible.
● Where needed people had equipment to help them remain independent. For example, one person had an adapted spoon and used a plate with raised sides. Some people required high calorie meals to ensure that they maintained a healthy weight, while others were following a weight reducing diet, high fibre or pureed diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Systems and processes for referring people for a wide range of services were in place; staff monitored people's physical and mental health and appropriate referrals were made to the relevant health care professionals.

● Staff worked closely with health and social care professionals to ensure people with complex needs and minimal communication continued to have consistent care.

● People were supported to access regular appointments to health professionals such as doctors and dentists; annual health checks were arranged with GPs in line with current best practice for supporting people with learning disabilities.

Ensuring consent to care and treatment in line with law and guidance

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. Where people are deprived of their liberty in their own homes applications must be made directly to the Court of Protection.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

At our last inspection we recommended that the provider consider guidance on the MCA and associated Code of practice. The provider had made improvements.

● People's rights under the MCA were protected. Where people were unable to decide about living at the service and having constant supervision a Deprivation of Liberty application had been submitted to the Court of Protection for authorisation. Restrictions on people such as the use of bedrails was included in the application.

● Where people were unable to make decisions about their care needs, a best interest decision had been made and had included the views of family members, staff and health and social care professionals. Capacity assessments had been completed to check people's ability to make decisions.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- There were good relationships between the people using the service and staff. We saw positive interactions in each of the supported living services we visited. Staff understood people's personalities and engaged with them in an appropriate manner. For example, one person liked to laugh and joke, and staff made the person laugh and smile. Another person was quieter, and staff ensured that they approached this person in a quiet respectful manner.
- People looked at ease and content with the staff who supported them. We saw people with limited verbal communication smiling and taking staff by the hand; staff spoke inclusively with people including them in conversation.
- People were supported to maintain their relationships with their family members. For example, staff would invite family members to share a meal with the person or to visit them for a cup of tea and a chat. This was important for one person who expressed a desire to see their relatives. Another person attended hydrotherapy with a family member, with staff support.
- People's care and support plans showed that people had been involved in making decisions about how they preferred to be supported. Staff offered people choices about their lives. For example, when we visited one person had some leaflets about activities and places to visit in the local area; they were deciding what they wanted to do over the weekend.
- People made day to day decisions about how their care and support were provided. For example, during people's initial assessment assistive technology was considered.
- People used a variety of methods of communication such as picture exchange communication systems or pointing at objects to communicate their choices. One person's preferred method of communication was non-verbal, and this was achieved through signs and using an electronic tablet to communicate. Another person was using specialist sign language to support their speech whilst communicating.

Respecting and promoting people's privacy, dignity and independence

- People were supported by staff who knew how to respect their privacy and dignity. Staff did not talk about personal things in public areas of the supported living settings.
- Staff could describe how they protected people's privacy and dignity during intimate care. For example, in one house a shower room had been developed to give the person more privacy and dignity that the facilities in the main bathroom provided.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were planned in ways that met people's needs and care preferences; some feedback raised concerns regarding consistent care delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care and support plans were detailed and reflected people's wishes and care preferences. They included guidance about the level of support needed and how people liked this to be done. For example, guidance included on how people communicated, daily routines and tasks they needed help with. This made sure all staff were aware of how to support them consistently. Care plans gave staff guidance on likely triggers and how to de-escalate and distract people who were anxious or distressed.
- Feedback regarding staff responsiveness was mixed. Some relatives and professionals reported staff knew people very well and were familiar with their needs. Others reported care plans were not as consistently updated and staff had not delivered care in line with agreed care plans. A regional manager told us any such occurrences were thoroughly investigated and additional measures taken to support these settings.
- Each person had a 'hospital passport', which contained important information other professionals would require should the person be admitted to hospital.

Meeting people's communication needs

From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Although people did not access their care plan on the provider's computer system information was provided in other ways. For example, staff shared information with some people using sign language to support their speech. This helped people visually process the information. Other people had a daily visual timetable or activity planner displayed in their accommodation. Staff told us they used this to show people what their planned activities were and reduce anxiety. One relative told us the activity planner was not always accurate; it showed staff support at times when they were not on site, which was confusing and difficult to understand.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's planned care and support was personalised, and their interests and hobbies were considered. An example of this was a person who went horse riding at the local stables.
- People were encouraged to take part in daily household activities hanging their washing out, cooking, and keeping their bedrooms tidy. Where people had complex health needs relatives felt they had fewer opportunities to keep busy during the day than they would wish. One said, "[Name] likes to look out of the

window. They would enjoy [staff support] to do that in the day."

● People were mostly supported to undertake a wide range of leisure to suit their skills and interests. For example, people attended drama groups and participated in shows and performances. Other hobbies supported were line dancing and visiting local attractions. In one supporting living setting a staff member was a keen gardener and supported people's interest in gardening. People told us how they visited the local market to get their vegetables and that they were planning to grow their own again this year. Other people enjoyed more individual pursuits, walking in the countryside, and listening to birds and music.

● Where possible people were supported to experience events, they wanted to see. For example, people had been to music concerts and holidays going to London to see a show.

● Staff sourced voluntary work and jobs for people. One person who was interested in bicycles and fixing things had a placement at a local bike store dealing in reconditioned bicycles.

● People were enabled to meet with others using the same service and would pop around to share a tea or coffee. In addition, they went to a local club to meet other people. One supported living setting had hosted some charity events supporting good causes such as guide dogs. People decided which charity they wanted to support and had invited family and friends to a coffee morning.

Improving care quality in response to complaints or concerns

● The provider had systems in place to manage concerns and complaints. All complaints we saw had been responded to in a timely manner.

● People knew who they could go to if they had any worries or were upset. One person said, "I talk to [Name of staff]. Staff could describe how people acted when they could not make a verbal complaint. For example, one person rocked or patted their head when agitated or in pain.

● Relatives knew who to raise their concern with at a local level. However, they did not always appear to know who to raise concerns with at provider level. Some relatives gave examples of where they had raised concerns and staff had acted upon them. Others however felt action had not always resulted in sustained improvements.

We recommend the provider reviews the management of complaints and concerns focusing on how they incorporate learning into daily practice.

End of life care and support

● At the time of inspection there was no one receiving end of life care; the service explored people's preferences and choices in relation to end of life care; the clinical lead informed us this was an area they would like to complete more work.

Good

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.

The service was consistently managed and well-led. Leaders and the culture they created demonstrated strong values of improving people's support and providing high quality care.

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

- The quality of care provided to people continued to be good. Staff had a good understanding of the individuals they supported, their likes, dislikes and preferences.
- People and relatives were mostly positive about staff and managers who they knew well. However, some felt staff changes had led to inconsistent staff practice and a decline in the quality of care.
- Staff told us they liked working for the service and felt supported and listened to; management were responsive when they raised concerns or ideas about how things could be done differently or outings that they could plan.

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, registered manager and staff spoke passionately about the people they supported and their work.
- When accidents or incidents had occurred people's relatives were informed as soon as possible.
- During the inspection, when any issues were identified managers responded proactively to resolve them.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Clear management structures were in place. The registered manager acted as a regional development manager who, together with area managers, provided support to teams at a local level. A range of specialist staff also supported the service.
- The provider had a vision to continuously find systems to help improve people's care.
- Systems were in place to monitor the quality of care and recognise what was going well and where improvements were required. When concerns were recognised through the auditing process actions were taken to resolve them.
- The registered manager fully understood their regulatory responsibilities; they notified the Care Quality Commission and local authority of significant events in line with guidance.

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

- A range of quality assurance surveys were used to obtain feedback from people using the service, relatives and staff. The compliance manager also spoke with people regularly to seek feedback on the quality of the service provided.

● Regular staff meetings gave staff the opportunity to suggest ideas for improving the service.

Working in partnership with others

● Staff worked with relevant external stakeholders, agencies and key organisations to support care provision, service development and joined-up care.