Care Quality Commission

Richmond Fellowship (The)

Carlisle Community Services

Inspection report

Logic House
Allenbrook Road, Rosehill Industrial Estate
Carlisle
Cumbria
CA1 2UT

Tel: 01229777101
Website: www.richmondfellowship.org.uk

Date of inspection visit:
20 July 2018
26 July 2018
03 August 2018

Date of publication:
05 September 2018

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

This inspection took place between 20 July to 3 August 2018. The inspection was announced

This was the first inspection of the service since it was registered to a new provider, Richmond Fellowship, in July 2017.

This service provides care and support to people with mental health needs living in 'supported living' settings, so that they can live in their own home 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.

Not everyone using Carlisle Community Services received the regulated activity; CQC only inspects the service being received by people provided with 'personal care', such as help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. There were two people receiving personal care and support at the time of this inspection.

There was a registered manager for the service. 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 safe care and were very comfortable with staff. Staff were trained in how to report any concerns and the organisation had clear protocols about protecting people.

There was very good continuity of care as the same small teams of staff had supported each person for many years. People received one-to-one support and staffing level matched this.

People needed help with managing their medicines and staff did this in a safe way.

Everyone supported by the service had been appropriately assessed. Staff were trained and experienced in supporting people, and keen to continue their learning.

A relative felt the service was very effective at meeting people's needs. The service worked alongside other health and social care professionals.

Over the past year there had been few opportunities for staff to have supervision sessions with a senior member of staff. Supervisions support the professional development of staff and can also make sure people receive consistent care. Also, there had been few staff meetings so staff did not always have opportunities to review people's care as a team. We have made a recommendation about this.

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.

People and a relative had very good relationship with the staff as they had supported the same people for many years. A relative described staff as compassionate, caring and professional.

Staff treated people with dignity and respect. Staff respected people's choices and decisions and supported them in a way which promoted their self-esteem and independence wherever possible.

People received a personalised service. Staff were very familiar with their individual preferences, lifestyles and needs.

Each person had person-centred care plans that described their individual needs and how they liked to be supported. These were created in an electronic format and staff reviewed them every three months. The provider needed to make sure that all staff had access to the records.

The provider had quality assurance systems in place and aimed to continuously develop its services.

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.

Staff levels were sufficient to meet people's needs. There were enough staff to provide one-to-one support for each person.

People felt comfortable with their staff team and staff knew how to report any safeguarding concerns.

Risks to people's safety were assessed and managed. People's medicines were managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive sufficient supervision to make sure they were supported and worked in a consistent way.

Staff were well trained and experienced in their roles. They understood people's rights and only carried out support with people's consent.

People's needs were assessed and regularly reviewed with other care services.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were caring, dedicated and supportive.

Staff understood how to assist people in a way that upheld their dignity.

People's choices and preferences were respected, and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

People received a personalised, tailored service based on each person's needs.

Care records included information and guidance about people's well-being and individual needs.

The provider had a clear complaints procedure about how to make a complaint or raise a concern.

Is the service well-led?

Good

The service was well led.

There a registered manager in place and new team leaders who were planning to improve the running of the service.

The provider had a thorough quality assurance system in place to identify areas for improvement and development.

The provider was part of a wider group of charitable organisations who were committed to supporting the recovery of people with mental health needs.

Care Quality Commission

Carlisle Community Services

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.

We gave the service 48 hours' notice of the inspection visit because it is small and we needed to be sure the registered manager would be in.

Inspection site visit activity started on 20 July and ended on 3 August 2018. It included visits to people using the service, meeting with a relative, discussions with health and social care professionals, discussions with two support staff and an email survey to all members of staff. We visited the office location on 20 July 2018 to see the registered manager and to review care records and policies and procedures.

This inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider information return (PIR). This 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.

During the inspection we also looked at the care records and medicine records of two people. We looked at the training records for all staff and the supervision records of five staff. We also viewed records relating to the management of the service.

Good

Is the service safe?

Our findings

People were comfortable with the staff that supported them. One person said the staff were "like family". A relative told us, "I trust them implicitly. It gives me peace of mind because they know [my family member] so well and provide 24 hour a day support."

Staff had regular training in safeguarding adults and knew how to reports any concerns. They understood their responsibilities to protect people and they had information in writing and on computer about the organisation's safeguarding adults' protocols. Staff also had whistleblowing guidance which meant they were aware of how to confidentially raise concerns about any poor practice. There had been no safeguarding concerns about this service over the past year.

The two people who used the service had one-to-one support for up to 24 hours a day. Each person had their own small team of three support workers who worked with them throughout the day and then slept-in at their house overnight. There was also a member of relief staff who covered holidays. Recently the provider had appointed two team leaders to manage the small teams. The team leaders were also able to provide cover if necessary.

It was clear from the rota that people always received this level of support. A relative told us, "Staff have worked with [my family member] for years and they are brilliant at continuity. They always cover each other so there are never any gaps and never any unfamiliar faces."

All the staff had worked for the previous provider and had transferred to the new provider, Richmond Fellowship, when it began operating the service. Staff had worked for the service for several years and there had been no new staff recruited since it registered one year ago.

The provider had safe selection procedures in place for recruiting any new staff. These included background checks and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions by reducing the risk of unsuitable people from working with vulnerable people or children.

Risks to people's health and safety were assessed and regularly reviewed. This included risks associated with people's mental and emotional well-being, as well as physical needs such as swallowing issues. It was clear from discussions with staff that they knew how to support each person in a safe way, whilst allowing people to maintain as much independence as possible.

Both people needed support with their medicines. Staff were trained in safe handling of medicines and had observed practice checks to make sure they were competent to help people manage their medicines. The staff we spoke with said they felt trained and confident in administering people's medicines. There were clear records of people's prescribed medicines, including what they were for and when they should be administered.

Medicines administration records (MARs) were used by support staff to record any medicines they had administered. Medicines were securely stored in locked cabinets and staff carried out a daily count of remaining stock. People were supported to have regular reviews of the medicines with their GP.

People needed some support with their personal hygiene. Staff had access to disposable aprons and gloves to make sure they supported people in a hygienic way. Staff had training in infection prevention and control.

There had been no significant accidents or incidents within this small service. Any accidents or incidents were reported to the registered manager and, if necessary, to the locality manager for action and oversight. The provider sought to learn from errors and used analysis of incidents across the whole organisation. It was evident that senior managers as well as health and safety officers monitored the incidents nationally for any patterns or trends and acted upon these.

Requires Improvement

Is the service effective?

Our findings

The two people who were supported had used this service for many years. They had regular reviews to assess whether the service was still meeting their needs. A relative felt the service was effective for their family member. They said, "Staff are excellent. The personal care they provide to [my family member] is of a very high standard."

The staff we spoke with felt that people's assessed needs were met. The provider was a national charitable organisation for people's recovery from mental health needs. It worked within national best practice guidance to support people towards improved lives and social inclusion.

Staff felt they had the right skills and were provided with enough training to support people. They described the training they completed which included health and safety, infection control, moving and assisting and food safety. Training records showed the training deemed essential by the provider was completed annually by each staff member. The provider used a computer-based management tool to identify when staff had received their training and when their refresher training was due.

Staff also completed other training in relation to people's mental health needs, such as bi-polar disorder. Staff were enthusiastic about training. One staff member commented that their training was "all linked to improved care practices" and relevant to the people they supported. It was good practice that all staff had completed a care qualification, including national vocational qualification level 2 or 3 in health and social care.

However, over the past year individual staff members had not received regular supervision with a line manager or an annual appraisal to discuss their performance and development. Some staff had only two supervisions sessions recorded and one staff member had no records of any supervisions with a senior member of staff. This was important because each member of staff worked alone so needed support to ensure they were working consistently and in line with people's needs and the provider's protocols. There had been few staff meetings so staff did not always have opportunities to review people's care as a team.

A health care professional felt the lack of supervision or staff oversight meant there was a risk that none of the staff would take the initiative if people's needs changed. The registered manager and locality manager acknowledged that this was an area for improvement. They stated new 'team leaders' had recently been recruited. They would take responsibility for individual supervision sessions with each staff member and would work alongside them for some shifts to make sure people received the same effective service.

We recommend that the service ensures a schedule of supervisions and appraisals are put in place to make sure each staff member receives regular support and guidance.

The provider used electronic care records for all its services. In each person's house there was a computer in the staff sleep-in room so that staff could record daily reports and update support plans. This meant office-based managers also had oversight of the most up-to-date records. At the time of this inspection one

permanent and one relief support worker did not have access to part of the system so were unable to complete daily reports. This meant they were writing the reports by hand and having to ask the next staff member to input the record. The locality manager stated they would address this.

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 the MCA.

Staff had training in the Mental Capacity Act 2005 (about people's capacity to consent)
and were mindful of people's rights to make their own decisions wherever they were able to. Staff were clear that people had the right to decline support. One person had a deprivation of liberty safeguard (DoLS) as they required constant supervision for their own safety. Their relative had lasting power of attorney and supported them with any significant decisions.

Both people required support with the preparation of meals. A relative commented that staff were "very good cooks" and made sure meals were tasty and appetising. People also needed support to make sure they were eating the right texture of food to make sure they did not choke and to make sure meals were nutritious. Their dietary needs were recorded in a support pan for staff to follow. People's weights were regularly recorded. One person had lost a lot of weight and had been referred to a speech and language therapist who had advised a 'soft' diet for a while. They had now put weight back on and had been discharged. The weight records showed that in one week the person had put on 10lbs, but staff had not questioned this. The registered manager agreed to check the calibration of the weighing scales used.

The agency worked in collaboration with other agencies where relevant. For example, support staff described how they worked in liaison with other health and social professionals, such as social workers and GPs. Regular multi-agency meetings were held about the people who used the service to check that their needs continued to be met.

Good

Is the service caring?

Our findings

People appeared very comfortable in the company of staff. We saw they were smiling and engaged with each other. One person told us they enjoyed being with staff and chatting with them. A relative had many positive comments about the care shown to their family member. They told us, "They should have a medal. He's very well-cared for and it's a lovely home-from-home service.

A care professional also made positive comments about the caring and compassionate nature of support workers. They told us, "They are the most dedicated staff ever. They've provided the service for up to 10 years. They care for each person as if they were a family member, and all the staff know the person so well."

Staff spoke about people in sensitive and valuing way. For example, one support worker told us, "We are all unique and we all have the right to be treated as individuals, as human beings." They also commented, "We treat [person] with the utmost respect. We're just guests in their house." A relative told us, "[My family member] is respected and liked by the staff."

Staff were calm, supportive and reassuring when talking with the people who used the service. They engaged them in conversations even if the person had limited communication. Staff were fully focused on the person and their emotional well-being. They included the person in discussions about things they might like to do and took time to watch for their responses.

Staff encouraged people to make their own daily choices and have control of their lifestyle wherever they were able to. For example, choosing what to do each day, where to go and what to have for meals. For one person this was very difficult because of their condition. Their relative told us, "The staff know [my family member] can't make their own choices, but they are very familiar with the things that [my family member] likes. The staff know what [my family member] likes to do and they are very flexible about what [my family member] like to do on different days."

People's independence was promoted wherever capabilities allowed. For example, one person was encouraged to be involved in shopping and helping to prepare meals with staff support. One staff member commented, "Our aim is to improve and maintain our clients' quality of life within a safe environment promoting positive choices and access to social integration and activities whilst promoting independence within the parameters of the client's own abilities."

People were treated with respect and dignity. A relative told us, "If [my family member] has done something positive or different they let me know. Staff really make sure their dignity is met and they absolutely value [my family member] as a person."

People's care records about their mental health needs were written in a sensitive way and promoted ways of supporting their self-esteem and relationships with others. Records about people's abilities were written in a positive way, for example one person's love of gardening and their progress with independent living skills.

One person had very limited communication and cognition and their relative was their legal representative to help them make significant decisions. The provider would arrange advocacy services if people needed this support.

Good

Is the service responsive?

Our findings

People or their relative were included in decisions about the care service they received. Each person's care records included information and guidance about the level of support they required. The care records were written in a personalised way that promoted each person's individual support needs. Support plans were reviewed every three months. The service also used 'star' outcomes, which is a way of tracking people's progress towards improved well-being in areas such as developing independent living skills.

It was clear from discussions with staff that people were at heart of their personalised service.
Each person had a team of three staff members who had supported them for several years. Support staff told us they were very familiar with the specific needs and preferences of the person they worked with. A relative told us, "They make [person's] life as they would have wanted it to be."

The relative also commented, "Staff know every little change in [my family member] and spot any non-verbal clues because they know [person] so well. The staff are so savvy and know what to do and what [person] needs all the time." Staff were extremely knowledgeable about each person and there had been no changes to personnel in years. The registered manager acknowledged that it would be helpful to use staff's understanding of one person to design a communication passport to set out their individual communication style and non-verbal language. This would help any new staff if there were future changes in support workers.

People's preferences were used to arrange their support. For example, one person could not tolerate support from a male member of staff so they were supported by an all-female staff team. The staff rotas were tailored-made for the two people who used the service. Staff worked 24-hour shifts (including sleep-ins) and felt this was beneficial to both people, especially one person as they could take all day to complete some tasks. One person had a two-hour 'independent' period in the afternoon. Staff risk assessed this every day to make sure the person was well enough to cope with this. The person had a mobile phone so could contact the staff if they needed them.

People were supported to lead active lives in their own community. One person described all the places they liked to go locally where they could meet up with other people. For example, to their favourite cafes, to a computer class at a museum, to a monthly church club and on coach trips with friends. A relative commented, "My family member goes out all over, everywhere. Their life is full of social events and activities." They described days out, cycling, cinema and wildlife parks that their family member was supported to visit and said that these were the things the person liked to do.

The provider had clear information about how to make a complaint, although at the time of the inspection this information was not available in people's houses. The registered manager stated people may once have had this information and agreed to make sure it was provided to them again. One person would not be able to voice any complaints but staff were very aware of their demeanour and would recognise if they were unhappy with a situation.

A relative told us they would have no hesitation in raising any comments about the service and knew how to contact the registered manager. They told us, "I have had to challenge the organisation about a few things, like not having staff supervision in my family member's house because it's not appropriate. But they do listen to reason and they act on any complaints or suggestions."

The service would be able to contribute to the delivery of end of life care if necessary. There were procedures about this in place and training was available in this area of care. The registered manager told us care at the end of life would be supported by a multi-disciplinary team approach which would include the GP, hospice services and other health and social care professionals.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. Both the registered manager and the locality manager were aware of the legal requirement need to notify the Commission of incidents and events. There had been no notifiable events over the past year. During the inspection, the registered manager and locality manager worked with us in an open and transparent way.

People were unable to express a view about the management of the service but a relative commented that the managers were approachable and responsive. They felt very able to contact the managers at any time and felt they "listened".

Recently two team leaders had been appointed to supervise the staff teams. A relative felt the management of the service would improve with the introduction of the new team leader role. They told us, "It's better now staff have a team leader, as they didn't always have someone immediate to go to." A care professional also felt this would be a benefit so that staff could collaborate as a team rather than work in isolation as lone workers. In the meantime, staff used handover reports, a communication book and telephone calls to relay any information to each other.

The provider used a national survey to ask people what they thought about their services. The two people who used the service had been offered questionnaires to complete but it was not possible to identify whether they had given any specific responses, as the survey covered all the services in the local area. Where they were able, people were involved in daily discussions about their support.

Recently staff meetings had begun to take place and this was an opportunity for staff to make suggestions as well as review people's care records and support plans. At this time, the outcomes from the meetings were only briefly recorded and there was no follow-up to show whether any suggested actions had been completed. The registered manager agreed to that the meeting minutes needed to be clearer and show any progress from the previous meeting.

The provider had a robust governance system to check its services. This included audits and analysis of incidents, accidents and events. The locality manager carried out monthly audits of support plans, risk assessments, consent records, and daily reports. The registered manager received monthly reports from the organisation about compliance with staffing matters. These included, for example, the level of staff sickness, staff vacancies, staff supervision, refresher essential training and medicines competencies for staff. There were organisational prompts for managers and staff about areas of work that should be completed within timeframes and these were checked by the provider.

During the inspection we spoke with the registered manager and locality manager about plans for the development of the service. The locality manager stated that there were plans for staff to be provided with smart phones so they would be able to access emails and records wherever they were. The smart phones would also be fitted with GPS so that managers would be able to locate a staff member and person when out in the community if there were any concerns for their well-being or safety.

The provider is a registered charity and one of the largest voluntary mental health support services in the country. It is part of Recovery Focus which is a national group of charities supporting people toward recovery.