Wakefield MDC

Wasdale Children's Resource Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 3, 4 and 5 July 2017 and was announced. Wasdale Children's Resource Centre provides personal care for children with a disability. This service is provided on a short term basis as an interim package of care, for example, when a carer needs additional short term support. The domiciliary care service is available between 7am and 9pm Monday to Friday. Referrals are made through the Social Work Team. At the time of our inspection Wasdale Children's Resource Centre provided personal care for one person.

Wasdale Children's Resource Centre has not been previously inspected.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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.

Both relatives told us they felt their family member was safe. There had been no safeguarding incidents to report since the service registered with the CQC. The registered manager was clear regarding what incidents they were required to report to the local authority safeguarding team and the CQC.

The service used permanent staff members from Wasdale children's residential home to provide the domiciliary care support. Staff told us there were enough staff to meet people's needs and they had sufficient time to deliver care. Appropriate recruitment procedures were in place.

In some care files, for people who had previously accessed the service, we found appropriate risk assessments were in place in relation to the domiciliary care service being provided. However, one person did not have a risk assessment to cover their needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a medicines policy and procedure in relation to their domiciliary care service. This is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had regular supervisions which they found useful. We recommend that the provider has a standing item on the supervision forms to discuss the domiciliary care service to ensure issues are not overlooked.

All mandatory training was kept up to date. We saw evidence this was the case for the permanent members of staff who provided the domiciliary care service.

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. All the staff members we spoke with understood the importance of respecting choices people made, and people's right to refuse care and support.

The relatives we spoke with confirmed staff worked at a pace to suit their relatives and staff treated their family members with respect. The relatives we spoke with stated they either would speak to the manager or their relative's social worker if they needed to make a complaint but neither had had to make a complaint. We recommend that the provider considers the information provided in their statement of purpose regarding the services offered by Wasdale Children's Resource Centre. There was no information regarding the complaints process to follow if a person wished to complain about the service regulated by the CQC.

Staff told us they felt supported in their role and that the management team listened to them. We saw regular team meetings were held in relation to all Wasdale Children's Resource Centre services and where appropriate the domiciliary care service was discussed. We recommend that the provider has a standing item on the team meeting agenda to discuss the domiciliary care service to ensure issues are not overlooked.

We looked at the systems in place to assess and monitor the quality of the service. Although feedback from people had been obtained, issues had not always been addressed. We found there were no clear and effective systems in place to assess and monitor the quality of the service. The registered manager told us they were no dedicated audit processes in place to monitor the quality of the service provision in relation to the domiciliary care service. The registered manager had begun to address this issue at the end of the inspection.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A risk assessment was not in place regarding a person's bathing needs to ensure risks were assessed or mitigated.

The provider had a recruitment process in place to ensure staff were of good character and that all checks were complete and satisfactory prior to letting staff deliver care.

The provider did not have a policy or procedure in place regarding the management of medicines within a domiciliary care setting.

Is the service effective?

Good

The service was effective.

Staff told us they were supported, and had regular supervision and training.

Staff members understood the importance of respecting choices people made, and people's right to refuse care and support.

Is the service caring?

Good

The service was caring.

People's rights, privacy and dignity were respected.

People's independence was promoted well and they were involved and informed about matters relating to their care and support.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in the care planning process. Staff told us they were alerted to any changes.

There were systems in place to respond to complaints.

The provider ensured a smooth transition between services by providing detailed handovers.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found the provider did not have sufficient systems in place to assess and monitor the quality of the provision.

Staff told us they felt supported by the management team.

Relatives told us they were asked for their views on the service and they felt listened to.

Wasdale Children's Resource Centre

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.

This inspection took place on 3, 4 and 5 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is in relation to children and young people who use care services.

We reviewed information we held about the service, such as notifications, information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England.

Prior to this inspection the registered provider had not been asked to complete 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 spoke with two relatives. At the time of inspection one relative's family member was receiving support from Wasdale Children's Resource Centre and the other relative's family member had recently used the service. We carried out a home visit and spoke to one relative over the telephone. We also spoke with three members of care staff, the registered manager and the two assistant managers.

We looked at a variety of documentation including; care documentation for three people, three staff recruitment files, meeting minutes, policies and procedures and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

Both relatives told us they felt their family member was safe. One relative said, "My relative was very safe with them, I never had to worry about them caring for my relative. The carers were amazing. I was 100% happy with them." Another relative told us, "Wasdale Children's Resource Centre staff are very polite and very understanding. It is a pleasure to have people come out who understand my relative's needs."

There had been no safeguarding incidents to report since the service registered with the CQC. The registered manager was clear regarding what incidents they were required to report to the local authority safeguarding team and the CQC. Staff told us they had received recent safeguarding children training and they were aware of their roles and responsibilities in reporting any concerns.

The registered manager told us there had not been any accidents or incidents. They provided a template of the form that would be completed if there had been. This would include an analysis of the incident and any learning identified. There was also a body map to complete, where appropriate.

The service used permanent staff members from Wasdale children's residential home to provide the domiciliary care support. We looked at two staff files and saw an appropriate recruitment process was in place. The registered manager told us the Human Resource department oversaw the recruitment process and ensured all the relevant checks were completed prior to staff commencing employment to help make sure staff were suitable to work with children.

The provider's policy was for staff to have their Disclosure and Barring Service (DBS) check updated every 5 years. The DBS is a national agency which holds information about people who may be barred from working with vulnerable people. We saw evidence to show staff had DBS checks every 5 years.

Both relatives confirmed staff were always on time and never missed any calls. Staff told us there were enough staff to meet people's needs and they had sufficient time to deliver care. The registered manager told us there was a sufficient pool of permanent staff to deliver the care package. They were clear they would not provide a service if there were not sufficient staff. The domiciliary care service was restricted to Monday to Friday between 7am and 9pm. This was because the main support the service anticipated providing was around getting people ready for school and for bedtime. The registered manager told us they would not routinely offer a service at weekends. However, in an emergency situation this would be considered. The service could only be accessed through a social worker making a referral.

In two of the care files we found appropriate risk assessments were in place which were sufficient in relation to the domiciliary care service being provided. For example, there were risk assessments for road safety, false allegations and asthma. However, it was not always clear from the risk assessments the date they had been completed. In one of the care files we looked at the person had risk assessments in place in relation to moving and handling. The domiciliary care agency provided a service where they bathed the person. However, this had not been covered within the risk assessment or care plan. This was particularly important as the person required a high level of support in this area. Although the person had a regular team of care

workers, there was a risk the person may not be moved safely if all care workers were not clear on how the person needed to be moved during bathing. The assistant manager ensured this was updated by the second day of inspection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Both relatives we spoke with told us staff did not have any involvement with their family members' medicines. Staff confirmed the person who currently used the service did not receive medicines as part of the domiciliary care package. Staff said they had received medicines training.

The provider's statement of purpose regarding the services offered by Wasdale Children's Resource Centre makes clear one of the services they offer through the domiciliary care service is the administrating of prescribed medication. We asked to see the medicines policy. We were provided with the 'Children's residential service medication policy October 2016'. The provider did not have a medicines policy and procedure in relation to their domiciliary care service. This meant there was no clear guidance for staff regarding their role and responsibilities in relation to the proper and safe management of medicines within the domiciliary care setting. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service effective?

Our findings

The relatives we spoke with considered the staff were well trained. One relative said, "I know my relative is very safe with the Wasdale Children's Resource Centre staff – they have gone through a lot of specialised training to work with my relative, including suction procedures. Staff are also trained to feed my relative through a tube." Another relative told us, "Carers were always so very friendly, very confident, so well trained. Worked so well as a team and were most careful with my relative."

Staff told us they had regular supervisions which they found useful. One member of staff told us, "We debrief – talk things through and discuss issues. They take action. I feel listened to." We saw evidence in the staff files to support this. We recommend that the provider has a standing item on the supervision forms to discuss the domiciliary care service to ensure issues are not overlooked.

Staff told us they received training in areas such as safeguarding, moving and handling, first aid and Therapeutic Crisis Intervention (TCI). TCI is a program for child and youth care staff which presents a crisis prevention and intervention model designed to teach staff how to help children learn constructive ways to handle crisis.

The registered manager told us a training matrix was used to ensure all mandatory training was kept up to date. We saw evidence this was the case for the permanent members of staff who provided the domiciliary care service.

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. We checked whether the service was working within the principles of the MCA.

All the staff members we spoke with understood the importance of respecting choices people made, and people's right to refuse care and support. They told us they would try different approaches such as trying again at a different time or with a different member of staff. Staff were clear they would report any concerns to the management team. Staff told us they had completed MCA training. However, we found staff were unsure as to what age the MCA applied. We raised this issue with the registered manager who told us they would ensure this was addressed.

Staff said they would involve people who used the service in their care plan. They would do this in consultation with the person's family. Staff were aware of involving advocates or other healthcare professionals, if appropriate. The relatives we spoke with confirmed this. One relative told us, "The unit manager came out and went through everything with me. She produced a fully comprehensive care plan, went through everything with me and left me a copy." Another told us, "We have review meetings every three months to discuss my relative's care. I tell them when changes are needed."

We saw the paperwork within the care files was signed by the person or a representative where appropriate. We saw evidence the service had been involved in best interests meetings with other healthcare professionals.

Staff said the service was very good at working with other healthcare professionals. Staff said they work with social workers, occupational therapists, staff at Martin House and nurses. We saw evidence of this.

Staff were aware of the eating and drinking needs of the person who used the service. Staff were aware of how to support people with complex needs. For example, staff had received training from a specialist nurse regarding feeding via a gastrostomy. A gastrostomy is a feeding tube that is inserted directly into the stomach. A gastrostomy tube allows the delivery of supplemental nutrition and medications directly into the stomach.

Good

Is the service caring?

Our findings

Both relatives we spoke with were happy with the service. One relative said, "The carers are very nice, very understanding." Another relative told us, "I am extremely happy with the service provided by Wasdale Children's Resource Centre. They were so brilliant."

The relatives we spoke with confirmed staff worked at a pace to suit their relatives and staff treated their family members with respect. One relative commented, ''Wasdale Children's Resource Centre staff work at my relative's pace, help my relative to get dressed. They always tell my relative what is going on and always treat my relative with dignity and respect.''

Staff told us there was a regular staff group who provided care to ensure consistency. We saw evidence to support this.

One relative told us that the service had a copy of their family member's end of life care plan. We spoke with staff regarding this. Staff were aware of the plan and the steps they were required to take to respect this.

Staff explained how they treated people with dignity and respect. One member of staff said, "I talk through the process and involve them. I'm discreet placing towels and knock before entering." Staff showed a clear understanding how they respected people's cultural and religious needs. For example, they respected a person's cleaning ritual in relation to hair washing. They were mindful of people's religious dietary needs.

Staff encouraged people to be as independent as possible. For example, one member of staff told us they put shower gel on a sponge and helped the person to wash themselves.

The registered manager told us people were involved in their care and they were encouraged to be involved and do things for themselves. We saw people signed their care plans, where appropriate. The registered manager told us they listened to people's feedback. For example, one person's allotted time was not sufficient to enable quality care to be delivered. The care package was therefore extended to meet the person's needs. We saw evidence to confirm this.

Good

Is the service responsive?

Our findings

Both relatives were very happy with the service provided. One relative said, "Wasdale Children's resource centre came in and sorted so many things, advised us on personal hygiene for my relative and helped clear up so many health problems." Another told us, "I wish this service was available all the time. They are so brilliant. They deserve an award."

Staff told us they assessed every session so that changes in needs were picked up on. We saw evidence of this in the contact sheets staff completed.

Staff told us care plans were up to date and easy to follow. We looked at three care files. Two care files were from people who had accessed the service in the past. We found the care files were difficult to navigate around. It was not clear from the care files the input the domiciliary care service was providing people. This was because the people had accessed other services offered by Wasdale Children's Resource Centre and this information was entwined within the domiciliary care files. These services are regulated by OFSTED.

The care plans we looked at were person centred and considered the needs and wishes of the person. For example, it was identified that a consistent team of staff would help the person to feel safe. This had been accommodated. One of the care plans we looked at had not been reviewed recently and did not reflect the current service being offered to the person. This matter is addressed under the well-led section of the report.

We looked at a selection of contact sheets. This is where each session with a person was recorded by a member of staff. It looked at the details of the session, whether there were any worries about the session, what needed to happen as a result and who had been informed about this. We found these to be detailed and showed the needs of the person had been considered. For example, one documented they gave the person time to settle with the staff prior to delivering personal care.

The relatives we spoke with stated they would speak to the manager or their relative's social worker if they needed to make a complaint but neither had had to make a complaint. Staff told us they would report any complaints to the management team. The registered manager told us there had not been any complaints regarding the domiciliary care service.

We recommend the provider considers the information provided in their statement of purpose regarding the services offered by Wasdale Children's Resource Centre. We noted the complaints procedure specified in this referred to the complaints procedure regarding the services regulated by OFSTED. There was no information regarding the process to follow if a person wished to complain about the service regulated by CQC.

Both relatives we spoke with told us there was good communication when their family member needed to use other services. One relative told us the manager visited them and completed a detailed care plan for the new care agency. They did this through liaising with the family and the new care agency. Another relative said their family member was to access another service for an overnight stay and staff were going to support

with this by introducing their family member to the new staff and new surroundings.

Requires Improvement

Is the service well-led?

Our findings

Both relatives were extremely happy with the service provided. Both relatives confirmed they were asked for their views on the service. One relative told us, "Every time Wasdale Children's Resource Centre take my relative out, on their return they give me an Information Sheet, telling me where they have been and what they have done. I have to fill in the 'Smiley Face' section – Staff do take notice of what I say."

There was a registered manager in post at the time of the inspection. Staff told us they felt supported in their role and that the management team listened to them. Staff were happy in their work. One member of staff said, "It's great." Another said, "I love it." We saw regular team meetings were held in relation to all Wasdale Children's Resource Centre services and where appropriate people who used the domiciliary care service were discussed. We recommend that the provider has a standing item on the team meeting agenda to discuss the domiciliary care service to ensure issues are not overlooked.

We looked at the systems in place to assess and monitor the quality of the service. The registered manager told us they obtained feedback on the service through evaluations forms which were completed at the end of each care package. These were completed by the person, social worker, relative and staff. They used these evaluations to look for areas of improvement. The reviews of these evaluations were not documented. We found one of the feedback evaluation forms raised an issue regarding the limitations of the service. It was recorded the limitations 'meant care could not be provided on an evening, weekend or holiday times. The idea was to replicate the service which adult services would put in but this was not possible.' We spoke with the registered manager regarding this, who confirmed this had not been followed up to help improve the service.

The assistant manager told us telephone feedback was also sought from relatives. We saw evidence this was done on an ad hoc basis but not at specific points within the care package. This meant opportunity may be missed to improve the short term care package.

The registered manager told us people's care files were reviewed. However, we saw one person's risk assessment and care plan did not cover their moving and handling needs and did not reflect the current service being offered to the person. The file had been reviewed in May 2017 and this had not been picked up at the review.

One of the contact sheets documented a member of staff raising an issue about staff position when moving and handling a person. The member of staff had documented they had raised this with a member of the management team. However, there was no further information documented to show what action had been taken by the management team to address this concern.

We found there were no clear and effective systems in place to assess and monitor the quality of the service. The registered manager told us they were no dedicated audit processes in place to monitor the quality of the service provision in relation to the domiciliary care service. The registered manager had begun to address this issue at the end of the inspection.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A risk assessment was not in place to ensure risks were assessed or mitigated to ensure a person's safety. There was no clear guidance for staff regarding their role and responsibilities in relation to the proper and safe management of medicines within the domiciliary care setting.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no clear and effective systems and processes for assessing and monitoring the quality of the service.