Aspire Community Benefit Society Limited

Farfield Drive

Inspection report

3A Farfield Drive
Farsley
Leeds
West Yorkshire
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19 October 2018

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

A comprehensive inspection of Farfield Drive, took place on 15 and 19 October 2018. This inspection was unannounced.

Farfield Drive is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service was developed and designed many years ago. The provider was working towards ensuring the service is in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Farfield Drive is a short break residential care service which aims to provide a holiday style atmosphere for up to five people who have a learning disability. Accommodation is in a purpose-built house with five bedrooms, each with en-suite facilities. Communal lounges, kitchen and dining areas are provided.

During our inspection there were three people staying at the respite service. The PIR received from the provider PIR said 56 people accessed the respite services within a 12-month period. At our last inspection the service was rated as good. At this inspection we found the level of compliance had not been sustained and we have rated the service as requires improvement. This is the first time the service has been rated requires improvement.

There was a registered manager in post at the time of our inspection, but they were moving to a new post within the company. A new manager was in the process of registering with Care Quality Commission (CQC). It was the new manager who we spoke with during this inspection. 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.

Some people using the service did not have capacity to consent to their care. We found people's care records did not include information to reflect that assessments had taken place where people lacked capacity, and there was not always evidence that best interest's decisions had taken place, where relevant. We also found DoLS applications had not been applied for when people lacked capacity to make certain decisions.

The provider had robust systems and procedures in place to keep people safe and staff were competent in their knowledge of what constituted abuse and how to safeguard people. There was a whistleblowing policy in place and staff knew how to raise concerns should this be required.

Medicines were managed safely with checks carried out to prevent possible medicine errors. 'As required' medicines were administered when needed.

Risk assessments had been completed and reviewed regularly. Accidents and incidents were managed effectively and actions taken to mitigate future risks.

Staffing levels were sufficient to meet people's needs and robust recruitment processes were in place to ensure people were of suitable character. Staff carried out training to ensure they had adequate skills and knowledge to meet people's needs. Staff were supported with regular supervisions and appraisals.

Health and safety checks were completed regularly and staff followed the providers procedures for infection control.

Staff were caring, kind and respected peoples wishes. We saw people were encouraged to remain as independent as possible using alternative communications to allow people to make choices about their care.

Pre-admission forms were completed to ensure people's needs could be met before their stay. Care plans were person centred and reviewed regularly with people and their relatives. Care plans included people's preferences, likes and dislikes.

People's privacy and dignity was respected. Staff knocked on people's doors before entering and did not wear identity badges when in public to respect peoples wishes.

Activities took place with people accessing the service to prevent social isolation.

People's nutritional needs were met and health professionals were involved in people's care when required. Hospital passports were in place which meant people's needs could be met when accessing care in another environment to ensure consistency.

The manager and team leader were honest and open. Staff told us they felt supported and felt confident to raise any concerns. Complaints were managed and actions taken to prevent future occurrences.

Regular meetings took place with people, staff and 'city wide' staff within the provider's company to obtain feedback and inform people of changes within the organisation.

The provider carried out audits to ensure quality assurance checks had been completed. This meant the provider had oversight of what was happening at the respite service. A customer involvement officer attended the service regularly to gather people's views and ensure actions were taken to improve the quality of care being provided.

The provider made improvements to enhance the quality of care being provided. They also had positive links within the community to ensure people did not feel isolated.

We found the service in breach of one regulation. You can see what action we directed the provider to take at the back of this 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?

Good

This service was safe.

The management of people's medicines was safe.

People told us they felt safe. Staff received training in how to protect people from abuse and how to respond if they suspected abuse was taking, or had taken place.

Risk assessments were in place for people who needed them and were specific to their needs.

Staffing numbers were sufficient to meet people's needs and recruitment was robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, capacity assessments had not been carried out which did not evidence compliance with the Mental Capacity Act 2005. DoLS applications had also not been completed.

Training and induction programmes were provided to give staff the skills and knowledge to meet people's needs. Regular supervisions and appraisals were also carried out.

People were supported with their nutritional needs and supported to access input from health professionals when required.

Is the service caring?

Good

The service was caring.

Staff were kind and caring towards those people accessing respite care. People were treated with care, dignity and respect.

People's care records detailed their wishes and preferences around the care and treatment provided. Reasonable adjustments were made to ensure people's needs could be met.

People were encouraged to be as independent as possible and involved fully in their care planning.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and were regularly reviewed. Individualised communication methods were used to support people to make choices.

People were provided with accessible information to help them make decisions about their care.

People were encouraged to join in activities to avoid social isolation.

Complaints were managed effectively and people told us they knew how to complain if needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have oversight of the need to apply the Mental Capacity Act 2005. Capacity assessments and best interest decisions had not always been recorded.

Audits were carried out to monitor and improve the service. An involvement officer spoke with people to gather people's views.

The manager and team lead were open and honest. Staff felt confident any concerns would be effectively managed.

Farfield Drive

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 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 had received a completed Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no information of concern from these agencies.

This inspection took place on 15 and 19 October 2018 and was unannounced. The inspection was carried out by an inspector.

During the inspection we spoke with the manager, team leader, two support workers and two people accessing respite care. (We observed care and support in communal areas and looked in the kitchen and peoples' bedrooms.) We reviewed a range of records about people's care and how the service was managed. We looked at care plans for three people, the recruitment, training and induction records for three staff, three peoples' medicines records, staffing rosters, staff meeting minutes, maintenance contracts and the quality assurance audits that the manager completed.

Good

Is the service safe?

Our findings

People who used the respite service told us they felt safe and one person said, "Yes I feel safe, I like my bedroom." We found people were protected from potential abuse or harm. Safeguarding notifications had been reported to the CQC and these were being managed effectively. The provider had robust systems in place for staff to follow and report any abuse. Staff could demonstrate their understanding of safeguarding procedures to ensure people were protected from any harm and told us they reported their concerns to the manager. There was a whistleblowing policy and staff felt confident to raise any concerns.

Risk assessments were carried out, regularly reviewed and updated to reflect people's current needs. Pre-admission forms included an up to date account of people's level of risk to ensure this could be met at each visit. We saw risk assessments in place for mobility, choking and personal safety. For example, one person at risk of choking was provided with small pieces of food and supervised by staff when eating to minimise the risk of choking.

Accidents and incidents were reported and investigated. Actions were taken and lessons learnt to prevent reoccurrence of incidents. We found one person had a seizure during their time in respite care. Staff timed the seizure to know when medical intervention would be required, checked the person over to ensure no injury and reported the incident to management.

Staffing levels were sufficient and we looked at the rota's which confirmed this. The manager told us staffing levels often changed due to dependency levels. For example, some people accessing respite care required one to one support from staff and that meant additional staff would be allocated for the person's stay. The manager said this was to ensure the quality of care always remained the same.

Staff recruitment checks were carried out. We checked three staff records which showed relevant checks had been completed. This included references, identification checks and a Disclosure and Barring Service (DBS) check. These checks help employers make safer recruitment decisions. There were no staff vacancies when we inspected and there was a full complement of staff working at the service.

Medicines were managed safely and people told us they received their medicines as prescribed. Medicines were checked in by two staff members when people came into the home for respite care. This ensured people had the right medicines for their stay and stock checks confirmed this. Staff competency checks had been carried out to ensure people were given their medicines as prescribed. Some people needed 'as required' medicines and protocols were in place to instruct staff when these would be needed.

Health and safety checks were carried out on a regular basis to ensure the premises remained safe. There was a fire assessment in place and every person had a Personal Emergency Evacuation Plan (PEEP) so staff knew how best to support people to evacuate the premises. Checks were also carried out on all equipment including hoists and slings used within the service to ensure they remained safe to use. The provider had an infection control policy which staff followed and audits were carried out to ensure the home was safe from infectious diseases.

Requires Improvement

Is the service effective?

Our findings

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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found capacity assessments had not always been carried out. Care plans did not contain decision specific mental capacity assessments or best interest decisions. We noted people were supported to take their medicines and some restrictive practices were being used to ensure people's safety. However, there were no mental capacity assessments or best interest decisions in place.

We found some information relating to one best interest meeting. However, this was not detailed. For example, restrictive practice was used to minimise a person's risk when out in the community in a wheelchair. Straps were used to prevent the person from leaving the chair due to their risk of safety and lack of understanding about dangers within the community. The care plan recorded that a best interest meeting had taken place but there was no record of the minutes of this meeting to show how this decision was made. Some people had their medicines administered covertly. We found letters from people's general practitioners confirming this was in place in the person's best interest. However, we found no capacity assessments had been carried out to show why these medicines were being given covertly.

DoLS applications had not been applied for when people lacked capacity to make certain decisions. The manager said they would immediately action DoLS applications for those people that lacked capacity. The manager told us that people's capacity assessments had been carried out prior to attending respite services although these were not always recorded within care files.

Although, people were offered choice, support plans did not contain decision specific mental capacity assessments or best interest decisions. This is a breach of Regulation 11(Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a clear understanding of people's capacity and those people who lacked capacity. One staff member told us, "Where people can make decisions we respect this. The MCA is about making decisions in people's best interest and we would seek advice from our manager."

There was an induction programme for new staff. This included shadowing of experienced staff and training. New staff also completed the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours. Staff received training which provided them

with the skills and knowledge to care for people accessing respite care. Training was completed by all staff. Some of the training courses included, moving and handling, safeguarding and MCA training. The manager monitored this to ensure staff had completed their training and when this was due to be updated.

Staff told us they received regular supervisions and annual appraisals. We checked three staff files which confirmed supervisions and appraisals had been carried out which followed the providers policy.

People were supported with their nutritional needs and offered choice. One staff member said, to promote choice and independence they decided to make homemade pizzas and people could put which toppings they chose onto the pizza's. Some people required specific diets that were determined by their religion. For example, some people required halah food and this was provided. One person said, "Yes, I choose what I eat. The food is very nice."

Individuals accessing respite care all had hospital passports which meant their needs could be met when accessing care in another environment to ensure consistency. We did find one hospital passport which had not been fully completed as the person's communication and personal care needs had not been recorded. We informed the manager of this and they agreed to add these details. Staff told us that should people require assistance when accessing respite, they would arrange for health professional input. We also found records of liaisons with other health professionals in people's care plans.

Good

Is the service caring?

Our findings

People told us staff were caring and supportive when they attended respite services. One person told us, "They [staff] talk to you and are caring. The staff look after me." One staff member said, "I treat people how I would want my family to be treated. I'm passionate about caring for people. We get time to spend with people here." We found positive relationships had impacted on people's experience of accessing respite care. For example, one person was previously restless, aggressive and often awake during the night when accessing the service. However, staff told us the person now enjoyed their stays, slept during the night and was less aggressive.

Annual reviews were carried out with people and their relatives. Health professionals were also invited to reviews. One person said, "Yes staff discuss my care with me." The provider used key worker roles within the service which meant people worked with staff who knew them well. Care plans included relevant information about who was important to people and who they wished to be involved in their care planning. One care plan stated, the person had a 'strong bond' with their father.

Staff had an understanding and respected people's privacy and dignity. One staff member said, "People have their own rooms with locks on the doors." Staff also told us they always knocked on people's doors to ensure people had their own personal space. One person living in the home used a straw to drink their tea and said staff always gave them a straw to ensure they did not spill the drink on their clothes, as this often happened. To protect the person's dignity the care plan instructed staff to immediately change the person's clothes should they spill food or drink on themselves.

Staff were aware of people's individual preferences. One staff member told us some people did not wish for staff to wear their identity badges when out in public with them, as they did not want the public to know they were accessing respite care. This meant everyone would be treated as equals. We found the provider made reasonable adjustments to accommodate people's individualised needs based on specific characteristics. For example, the provider had agreed to female only weeks to accommodate people whose religious beliefs meant that they did not wish to attend respite with males.

Due to there being a variety of people with complex needs that attended the respite services staff told us person centred care was delivered by making reasonable adjustments for people's stay. For example, staff did a quiz every week but changed the questions to suit those who were staying at the time. This meant that people enjoyed the quiz because questions were asked about the topics they most enjoyed.

People were involved in discussions about their care and the wider organisational changes. One care plan detailed, 'I would like all staff to involve me in the decisions that are made when I am on respite and to involve me in all activities.' The manager also told us people accessing respite services were involved in the interviewing process to ensure they employed staff that were suitable to meet people's needs. One person who accessed the service also volunteered and carried out cleaning in the home once a week.

People were supported to be as independent as far as possible. We found care plans instructed staff on how

to support people to be independent. For example, one person's hygiene plan detailed, 'Please ask me if I would like bubbles in my bath, please support my independence and offer me my flannel and soap so that I can attempt to wash myself.'

Some people living in the home had an advocate. An advocate is a person who can support others to raise their views, if required. The manager told us that should anyone wish to have an advocate they used a local agency which people had access to.

Information about people was kept securely in locked cupboards at all times and the provider was compliant with the Data Protection Act. Staff told us they were aware of keeping personal information confidential and they knew how to access this information.

Good

Is the service responsive?

Our findings

Initial assessments had been carried out by the local authority and we saw these recorded in people's care files. The manager told us they invited people to the respite service to speak with them, identify their needs and ensure they felt comfortable in the home. Pre-admission reviews were done a week before people came into respite care. These reviews were bought in following an incident. Lessons were learnt about ensuring staff had relevant and up to date information about people's care before they attended at every stay.

Person centred care plans had been developed with people. For example, to make a person feel comfortable when they received respite care they brought a large soft toy to the home. The care plan stated, 'I always bring in my large fluffy snake, this gives me comfort and helps me to relax, especially through the night. I also like to have a picture of my family next to my bed.'

People were offered choices about their care. Staff offered people a choice of clothing so they could pick what they wanted to wear. Upon each visit to the respite service staff told us they sat and arranged weekly planners with people to ensure they choose what they wanted to do. There were clear instructions in place for staff to follow with regards to people's communication needs. For example, one person sometimes used Makaton sign language to communicate needs such as 'more' and 'finished'. If the person wanted a drink they would show staff their empty cup. Staff would ask the person to point or show staff what they wanted to ensure choice.

People accessing respite services told us they participated in activities. Some of these included trips to Blackpool and Bridlington. The manager told us some people attended sixth form college as part of their daily routine and others were involved in volunteer work at a café to help people develop their employment skills. We also found people were given a list of events and activities on each month within the local area.

Staff were knowledgeable about people's likes and ensured activities were carried out to meet their preferences. We found people's interests had been recorded in their care files so staff knew what they enjoyed. For example, one person's care file said they enjoyed train watching and trampolines but disliked shopping. One staff member said they often took the person to visit trains because they enjoyed this.

Complaints were managed effectively. The manager kept a log book to ensure there was oversight of complaints being received. We found one complaint had been received over a 12-month period. The complaint was responded to and actions taken to prevent future issues. The provider also received compliments, one relative commented on the support the provider gave to the person when their family member was taken ill.

The manager was aware of the Accessible Information Standard that was introduced in 2016. This standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. They told us they provided and accessed information for people that was understandable to them. We found interview questions that people used had been provided in an easy read and pictorial format to support them with the interviewing process for new staff.

We found people accessing the service had come from children's services and were transferring into adult care. The manager said they made reasonable adjustments to ensure people felt safe and enjoyed their time at the service. To facilitate this transition the manager told us they invited people for tea visits so they could meet staff and build relationships. Staff also attended people's schools and spent time with their family to understand people's needs. The manager said this was usually over a three-month time period to allow for adjustments to be made or training for staff should people have specific needs.

The home did not support anyone who was approaching the end of their life.

Requires Improvement

Is the service well-led?

Our findings

We found the provider did not have oversight of the need to apply the Mental Capacity Act and the application of DoLS. We found capacity assessments had not been carried out when people lacked capacity to make decisions regarding restrictive practice, medicines administration, personal care and finances. Therefore, we have rated this domain requires improvement as the provider did not have oversight of the need for capacity assessments and DoLS within the service. We discussed this with the manager who said they would implement these changes immediately. Following the inspection, the manager informed CQC of what actions they had already taken.

Staff told us the management were supportive and people felt listened to. One staff member said the management were okay and responded by saying, "We have really good staffing because you can have personalized time with people. I feel I'm making a difference to people's care, I get job satisfaction and like coming to work." Staff told us they would feel confident to raise concerns. One staff member said, "Yes I would complain. If it was something the manager could deal with then I would go to them." During the inspection the manager and team leader were open and honest when asked questions about the care being provided.

Systems were in place to monitor the quality and safety of the service. We saw health and safety audits were routinely completed. A monthly health and safety checklist was carried out. Monthly infection control checks were completed and medicines. We noted that these audits were effective. Also, pre- admissions forms were used to determine if people needs had changed since their last stay to ensure care plans could be updated in advance of their stay.

Surveys had been carried out however, these were not specific to the respite service and reflected the views from people in all the providers services. To gather people's views there was a customer involvement officer who attended the service to ask people about their experiences. This was then fedback to the provider so improvements could be made.

The manager told us of a variety of improvements the respite services had been working towards. For example, to promote different cultures they introduced theme nights. We saw a Polish night had been organised for people to experience different foods. They were also planning a refurbishment of the home and this will be in consultation with people accessing respite care.

There were positive links within the community. People living in the home told us they often went out with staff into the local area and into Leeds. The service bought a car to ensure community access was available to all of those people accessing respite care. This also meant they could arrange trips further away such as day trips to the seaside. The provider had a monthly events calendar of what was happening. For example, a lights night event in the city centre.

Regular meetings were held with people who stayed at Farfield Drive. We saw topics were discussed, which included food, communication and involvement. In-house staff meetings, along with 'City wide' staff

meetings, which included staff from all the provider's services, had taken place on a frequent basis.

There was a registered manager in post. However, the registered manager now had a new post within the company. The new manager was in the process of making an application to become the registered manager and had oversight of five services run by the provider. At Farfield Drive the manager was supported by a support leader, who managed the day to day running of the home. Statutory notifications had been received by the CQC in line with legal requirements and we found incidents and accidents had been referred to the relevant services such as safeguarding when required.

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
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not comply with the Mental Capacity Act (2005) as the process to evaluate the need for Deprivation of Liberty Safeguards (DoLS) had not been completed and mental capacity assessments had not been carried out.