My Life-My Choice Limited

Big Blue Door

Inspection report

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15 June 2017

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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

We carried out this inspection on the 14 and 15 June 2017. The inspection was announced and was the first rated inspection for the service. We gave the service 48 hours' notice of our inspection to make sure people were in the office and arrangements could be made to visit people in their own homes with their consent.

Big Blue Door is registered to provide personal care for adults and children who have learning disabilities, in their own homes. On the day of our inspection there were two people using the service. We were not able to verbally communicate with these people during our inspection.

At the time of our inspection the service had a registered manager in post. 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.

Staff had received training in safeguarding and knew their responsibilities to report any concerns. The service also had a whistleblowing policy in place.

Risks to people who used the service had been identified but we found risk assessments had not been put in place. We discussed this with the registered manager who told us they would action this as a matter of urgency. The day after our inspection the registered manager sent us the required risk assessments. These identified risks and how staff were to mitigate them to keep the person safe.

Recruitment systems and processes in place were robust. We saw references, identity checks and Disclosure and Barring Service checks were completed before staff were employed.

Medicines were managed safely in the service. Only staff members trained to do so were able to administer medicines to people. We have made a recommendation about the medicines policy in place in the service.

We saw accidents and incidents were recorded and retained in both an accident book and on an accident and incident sheet which the provider had developed, a copy of which was retained in the person's home in their care records.

Staff told us they had access to personal protective equipment (PPE) such as gloves and aprons and confirmed they had received training in infection control. We have made a recommendation about the infection control policy in place.

All new staff members were expected to complete and induction when they commenced employment. Those who did not have a qualification in health and social care were expected to complete this during their employment. We saw staff completed further training in topics such as safeguarding, medication, autism, food hygiene, equality and diversity, challenging behaviour, disability awareness, communication and

epilepsy awareness.

Staff members told us and records confirmed that staff members received supervisions and appraisals on a regular basis. All staff members told us they were able to discuss any training requirements they had.

We observed some carers undertaking tasks in people's homes. We observed they were kind, caring and respectful in their interactions with people and respected people's privacy and dignity when undertaking personal care tasks.

People's independence was promoted on a daily basis. Staff encouraged people to undertake daily living skills such as washing their clothes, cleaning the house and cooking their meals.

Care plans in place for people contained detailed information to direct staff on how to meet people's needs.

Staff meetings were held on a regular basis. Records we looked at confirmed staff were able to bring up topics or suggestions in these meeting.

There were quality assurance processes in place which included regular audits and checks on the operation of the service.

We have made a recommendation about the statement of purpose currently in place within the service.

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.

Relatives told us they felt their family member was safe using the service and staff had received appropriate training.

Recruitment systems and processes were robust to ensure that only staff suitable to work with vulnerable children, young people and adults were employed.

Records showed there were adequate staffing levels deployed to meet the needs of people who used the service. Agency staff were being used at the time of our inspection but the provider was recruiting new staff members.

Is the service effective?

Good

The service was effective.

Staff members we spoke with and records we looked at confirmed that staff undertook an induction when commencing employment with the service.

The registered manager was aware of their responsibilities in relation to the MCA 2005. The service had made the relevant applications to the court of protection for one person using the service.

People who used the service had access to healthcare and external professionals such as GP and the community learning disability team.

Is the service caring?

Good

The service was caring.

We received very positive feedback from relatives and professionals about the kindness and support given by the registered manager and staff members.

Staff members were very respectful of people's privacy and dignity. For example, we saw staff members knocked on the

person's front door before entering and asked if they could sit down.

Confidential information was appropriately stored so that only those permitted to access it could do.

Is the service responsive?

Good

The service was responsive.

Care plans we looked at were person centred and contained detailed information about the person's likes and dislikes, daily routines and provided guidance for staff.

We saw a wide range of activities were offered to people who used the service.

People who used the service were given choices, such as what time they got up, what time they went to bed, what they wanted to wear and how they wanted to spend their day.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who was registered with the Care Quality Commission (CQC).

We saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager.

The service worked in close partnership with other professionals such as the community learning disability team, social workers, GP's and speech and language therapist's (SALT).

Big Blue Door

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 checked 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 was a comprehensive, announced inspection which took place on the 14 and 15 June 2017. The inspection team consisted of one adult social care inspector and one adult social care inspection manager on the first day, and one adult social care inspector on the second day.

We did not request the provider to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service including notifications the provider had sent to us. We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any concerns.

During the inspection we visited one person who used the service. This person was unable to communicate verbally with us; however we spoke with their relative and undertook observations of interactions from care staff members. We also spoke with the registered manager, one team leader and one care staff member.

We looked at the medicine records for one person who used the service and care files for both people. We also looked at a range of records relating to how the service was managed; these included five staff personnel files, training records, rotas, complaints, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

One relative we spoke with told us they felt their family member was safe. They commented, "Yes, my [family member] is absolutely safe."

Staff members we spoke with knew how to keep people safe. One staff member told us, "I would inform the registered manager if I had any safeguarding concerns. If I felt they were not doing anything about it I would go higher."

We saw from the training matrix and staff files that staff had received safeguarding training. Staff had policies and procedures to report safeguarding issues. This procedure provided staff with the contact details they could report any suspected abuse to including details of how to raise a safeguarding alert with the local authority. The policies and procedures also informed staff about the types of abuse, how to report abuse and what to do to keep people safe. The service also provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith.

On the second day of our inspection, we found risk assessments had not been put in place for one person who used the service. However, risks had been identified and action had been taken to keep the person safe, for example covers on radiators to prevent burns. We spoke with the registered manager regarding this. They told us the task of implementing risk assessments had been given to a staff member that was no longer working at the service; however they reassured us they would ensure they were implemented as soon as possible. The day after our inspection the registered manager sent us the completed risk assessments that had been put in place. These were detailed and provided staff with guidance on keeping the person safe.

Care records we looked at contained a document called 'In case of fire'. This directed staff on the action to take in the event of a fire and how best to support the person to evacuate. This should ensure that staff members know how to safely evacuate people who use the service in an emergency situation.

The service had an accident and incident policy in place. This gave staff information about what constituted an accident or an incident. We saw accidents and incidents were recorded and retained in both an accident book and on an accident and incident sheet which the provider had developed, a copy of which was retained in the person's home in their care records. The registered manager told us all accidents and incidents were reviewed once a month to assist in spotting any trends and to mitigate further risks.

We looked at the systems in place to ensure staff were safely recruited. The service had a recruitment policy in place to guide the manager on safe recruitment processes. We reviewed five staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and were considered safe to work with vulnerable adults and children.

We asked the relative of one person who used the service if they felt there were adequate staffing levels to meet the needs of their family member. They told us, "Yes there is always two staff during the day and one staff at night time. There's always enough."

The registered manager informed us they had recently had a large number of staff leave employment at Big Blue Door, either of their own accord or through disciplinary procedures. As a result they had been using an agency to support with staffing levels. We were reassured by the registered manager and the records that we looked at that none of the agency staff were supporting young adults in their own homes. This support was provided by permanent staff who were deemed to have the necessary skills and experience to support and meet people's needs.

We reviewed the systems in place to ensure the safe administration of medicines. Only staff members that had completed medicines training were permitted to administer medicines within the service.

We asked the registered manager how they ensured medicines were managed safely in the service. They told us, "The medicine policies we need to look at, but everything gets audited and checked in terms of signatures and medicines have to match the records." We looked at the policies and procedures for the administration of medicines. We found the medicines policy had recently been re-written; however, we noted the information contained within the policy was very limited and did not focus on supporting people with their medicines in a community setting.

We recommend the service considers current best practice guidance around the management of medicines in a community setting in order to produce a policy and procedure which will adequately guide staff.

We looked at one medicines administration records and found this had been completed accurately. There were no unexplained gaps or omissions and all entries were legible. Medicines were stored in a locked cabinet attached to the wall in the kitchen of the person's home.

There were policies and procedures in place for the prevention and control of infection. However, we found these did not relate to a domiciliary care agency and contained limited information.

We recommend the service considers current best practice guidance in relation to infection control and establishes a policy and procedure that is suitable for a domiciliary care agency.

We saw from the training matrix staff had been trained in infection control. Staff had access to personal protective clothing such as gloves and aprons should they require them.

Good

Is the service effective?

Our findings

We asked one relative if they felt staff had the necessary skills and knowledge to meet the needs of their family member. They told us, "Yes, by enlarge. Since [family member] has been in the service one or two have left and new staff have started but generally speaking they know [family member] well."

Staff members we spoke with confirmed that had received an induction prior to commencing employment. One staff member told us, "I had an induction over two days. I was on shadow shifts observing and working with other people to find out how they worked with people who used the service. I had to look at the policies and procedures and the clients files."

Induction records we looked at showed that staff completed an induction when commencing employment within the service. All new staff members undertook training the provider deemed necessary for their role and included looking at policies and procedures. During our inspection we noted a newly recruited staff member was shadowing more experienced staff. This gave the staff member time to settle into their new role as well as allowing the person using the service to get to know them. This was of particular importance when working with people who have a diagnosis of and living with a learning disability. The registered manager also told us new staff members without any qualifications in care were expected to enrol in further education such as diploma in health and social care.

One staff member told us, "Staff training is constantly updated on the rota so we know when our next training session is." We looked at the training matrix and saw courses available to staff members included safeguarding, health and safety, first aid, moving and handling, medication, autism, legislation, record keeping, food hygiene, equality and diversity, challenging behaviour, disability awareness, communication and epilepsy awareness. The registered manager told us, "We use an online training provider and buy in face to face training as well."

The service had a supervision and appraisal policy and procedure in place. This gave staff members information on what a supervision was, what an appraisal was and the aims and objectives of supervisions and appraisals. We saw staff members had signed a supervision contract as an agreement between them and the service to be involved in regular supervisions.

Records we looked at confirmed that supervisions were held regularly. Discussions within these took place around areas such as, the individual needs of people who used the service, manager feedback, training, work duties and shift patterns. Staff were also given the opportunity to bring up topics for discussion if they so wished.

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. Any applications to deprive someone of their liberty for this service must be made through the Court of Protection. We checked whether the service was working within the principles of the MCA.

We found the provider had made an application to the court of protection for one person who lacked capacity to make their own decisions, with the support of the community learning disability team. At the time of our inspection they had not received any information to state if this was in place.

We recommend the registered manager seeks clarification from the necessary people to ensure all relevant information and permissions are included in the person's care records.

During our observations in one person's home we noted staff regularly asked for consent from the person. For example, staff asked if they could enter their home, if they could use their toilet or if they could sit down. Whilst the person using the service was non-verbal in their communications they put their thumb up to show their agreement/consent to any questions asked, or down if they did not consent/agree.

Records we looked at showed people had access to a range of healthcare professionals in order for their health care needs to be met. We saw the registered manager had made arrangements for the person's GP to visit them in their own home as taking them to the surgery was extremely anxiety provoking for the individual. This showed the provider had considered the needs of the person.

All staff members had received training in food hygiene and it was part of their role to support one person to make their own meals. We asked one staff member how they supported people to make their own choices in relation to the meals they had, in particular a person who could not communicate verbally. They told us, "We take her to the fridge and ask her what she wants. The other day she had a choice of chicken or fish fingers with mashed potatoes or waffles. She chose the waffles over the mashed potatoes and then she chooses her own vegetable. She will take you to the cupboard if she wants ketchup. She is able to make her food choices known."

There was also an 'eating plan' located in the person's care records. This was to provide guidance for staff on how to promote a healthy and balanced diet for the person, including what foods should be offered in moderation, such as crisps or high fat meals.

Good

Is the service caring?

Our findings

We asked one relative if they felt staff members were kind and caring. They told us, "Yes, they are very kind and caring. I could not be happier with the care being provided. I am very, very happy, [family member] is very happy and her needs are being met. I am over the moon." Staff members we spoke with told us they would be happy for one of their family members to be cared for by the service.

One external professional we contacted told us, "[Registered manager] provides a good quality service and works in collaboration to arrange and coordinate appropriate services to meet an individual's need. I know that families hold [registered manager] and her team in high regards, families often state that the service she offers is a vital part of their lives."

The registered manager told us they were proud of the caring ethos of the service. They said, "We are genuinely service user led. It is not about us or the staff, the client comes first." Throughout our inspection the registered manager consistently spoke about people in a caring manner and the aspirations she had to ensure people received high quality care.

In order for us to observe staff members interactions with people who used the service, we visited one person in their own hone. We observed that staff members' approach was calm, sensitive, respectful and valued the person. Staff showed kindness and compassion when they were supporting and encouraging the person with their daily living skills.

People's privacy was respected; staff knocked on people's front door before entering their home. We looked at records and found staff wrote about people's needs and care in a respectful manner. There were training courses and policies and procedures for staff which helped them understand how they should respect people's privacy and dignity in their own home.

We observed that all personal and confidential information was appropriately stored and only those people who were permitted to access it could.

Care plan's detailed people's personal choices and routines. There was a document which highlighted the things that were important to the person. This gave staff detailed information about people's likes and dislikes and what hobbies or activities they wanted to do. This meant that the support given was what the person wanted.

Promoting people's independence was important within the service. One person's care records we looked at contained detailed information for staff about how to encourage the person to remain as independent as possible. For example, how to encourage the person to clean their home, to wash their clothes and to assist with making meals.

We saw that visiting was open and unrestricted and people were encouraged to maintain relationships with their family and friends.

Good

Is the service responsive?

Our findings

We looked at the care records for one person who used the service. We noted the service had supported the person since they were a young child and had provided support through transition into adult services. The care records contained detailed information to guide staff on the care and support to be provided, including what the person was able to do for themselves. There was good information about the person's social and personal care needs. The persons' likes, dislikes, preferences and routines had all been incorporated into their care plans; what time the person liked to go to bed, how often they liked a shower or a bath and what they liked to do during the day. There was also detailed information relating to the person's complex needs, such as early warning signs that the person may display behaviours that challenge and how staff were best to support the person.

Care plans were reviewed on a monthly basis to ensure they reflected the person's changing needs.

We asked staff how they ensured they gave people choices. We were told that the person was given choices throughout the day including what time they got up in a morning, what time they went to bed, what they wanted to wear, what they wanted to eat and how they wanted to spend the day. Care records we looked at reflected what we had been told.

One relative told us they felt their family member had enough activities and was able to access the community. They told us, "She doesn't get out a lot but the process has been challenging due to her presentation and anxiety when she is going out of the house."

We spoke with the registered manager regarding this who confirmed it had been difficult to access the community although they were finding ways around this in order to ensure the person was able to enjoy the local area. Other activities were regularly available during the day in the person's own home. Records showed that activities they had undertaken included, baking, going for a walk along the canal, having her hair and make-up done, shopping, arts and crafts, going to the bank to collect money, jigsaw's and a trip to the beach.

The service had a complaints policy in place. However, reference was made to the Care Quality Commission as a contact if the person was not satisfied with the outcome, rather than a referral to the ombudsman. We saw one complaint had been received and recorded, including the response.

We asked the registered manager how they dealt with complaints within the service. They told us, "We do a full investigation. I sit and listen to them first of all, objectively. People do get disciplined it is deemed necessary." One staff member told us, "I would write the complaint down and document it, pass it on to whoever was next on duty and also pass it on to the registered manager."

We asked one staff member how they were kept informed when people's needs changed. They told us, "Either in the communication book or when we handover." We saw the communication book was used to hand over any important information between staff members. We also saw comprehensive daily notes were

made about the person who used the service. For example detailing what the person had eaten throughout the day so their dietary requirements could be monitored.

Good

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC).

People spoken with made positive comments about the leadership and management of the service. One staff member told us, "I have had good support from staff and the registered manager. They have asked me if I have settled in and if I like the job." A relative told us, "I can always get hold of [registered manager] if I need to, about anything." The registered manager was actively involved in ensuring the service was compliant with regulations and delivering good quality care. One external professional told us, "With confidence, I can confirm that [registered manager] is committed to improving the quality of life for young people affected by disability."

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

There were policies and procedures for staff to follow. We looked at several policies and procedures which included safeguarding, whistleblowing, medicines, infection control, recruitment, moving and handling, accident reporting and confidentiality. These were accessible for staff. We have already made recommendations within this report in relation to issues we found with some of the policies and procedures.

The registered manager told us and records showed how the quality of the service was monitored. We saw audits were undertaken in relation to medicines, supervisions and appraisals, accidents and incidents, care plans and care records. There was also an online system of auditing which the registered manager used which sent alerts to them, for example if supervisions were due or if staff training required updating. These systems and processes should ensure the service consistently improved.

Due to only two people using the domiciliary care part of the service, meetings were held in each person's home with their relative to discuss their care and support needs and if there were any concerns. This formed part of the review of their care package.

Staff meetings were held regularly. Staff were invited to bring up topics they wished to and we could see from the agenda that discussion were held around the care people who used the service needed, things staff could do better, medicine issues, rotas, challenging and complex clients. The staff member we spoke with had not worked at the service long enough to have attended a staff meeting so we were unable to ask their opinion.

The service had a statement of purpose in place. However it was difficult to differentiate between the service which was regulated by the Care Quality Commission and those which were regulated by another organisation. We spoke with the registered manager regarding this and the need for this document to be clear. We were assured the service would look to make the necessary changes to this document.

The registered manager told us a key achievement of the service was the excellent working relationship they had with family members and professionals and how they all worked together for the needs of the person using the service. They went on to tell us that a key challenge for the service has been trying to fit the service into the regulations and retaining good quality, high calibre staff members.

We also asked the registered manager what their visions were for the future of the service. We were told they were looking to open a four bedded respite service for young adults and they wished to purchase a large plot of land in which they could site 12 log cabins. The aim being to give people whose needs were complex and challenging the freedom to be outdoors.

The service worked in close partnership with other professionals such as the community learning disability team, social workers, GP's and speech and language therapist's (SALT). This should ensure the needs of people using the service are met.