Community Integrated Care

Wensley Street

Inspection report

132-142 Wensley Street
Grimesthorpe
Sheffield
South Yorkshire
S4 8HN

Tel: 01142611934

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05 June 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

.The inspection was unannounced, and the inspection visit was carried out on 5 June 2018. The home was previously inspected in March 2017, where concerns were identified in relation to medicines management and governance. At that inspection the home was rated "Requires Improvement."

This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. People using the service lived in six neighbouring houses, with office accommodation on the same site.

Care services for people with learning disabilities should developed and designed 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.

At the time of the inspection the service had a registered manager. 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 and associated Regulations about how the service is run.

Staff did not always ensure that people were engaged with when at home, meaning that people were at risk of social isolation. However, we found that people were supported to engage in activities in the community.

Care plans were not always personalised to people's individual needs, and risk assessments were not always adhered with.

We found that the way that medicines were managed at the service required improvement so that people received their medicines as prescribed.

The provider did not always comply with the Mental Capacity Act in relation to consent and making decisions in people's best interests.

The provider ensured that when people's needs changed appropriate referrals were made to external healthcare professionals, and people's needs were met in relation to nutrition and hydration.

There was a comprehensive programme of audits within the service, however, they had not identified shortfalls or concerns within service provision.

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.

We found that the way that medicines were managed at the service required improvement so that people received their medicines as prescribed.

Staff were familiar with safeguarding processes, but people's risk assessments were not always adhered to.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were met in relation to nutrition and hydration.

The provider did not always comply with the Mental Capacity Act in relation to consent and making decisions in people's best interests.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always ensure that people were engaged with, meaning that people were at risk of social isolation.

Care plans were not always personalised to people's individual needs.

Is the service responsive?

Good

The service was responsive.

The provider ensured that when people's needs changed appropriate referrals were made to external healthcare professionals.

People were supported to engage in activities in the community.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a comprehensive programme of audits within the service, however, they had not identified shortfalls or concerns within service provision.

Wensley Street

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.

The inspection was unannounced, which meant that the service's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out on 5 June 2018 and was carried out by two adult social care inspectors.

During the inspection we spoke with four staff members, the registered manager, a member of the provider's senior management team and three people who were using the service at the time of the inspection. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We checked the personal records of six people who were using the service. We checked records relating to the management of the home, personnel and training records, meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the home's management team. We observed staff undertaking various activities, supporting people to make decisions and express their views.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. Before the inspection, 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. This was returned in a timely manner and completed to a high level of detail.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in March 2017, we identified concerns in relation to how medicines were managed. We therefore rated the service as "requires improvement" for this domain. We continued to find further concerns at this inspection.

People who could give us a view told us they felt safe receiving support services from Wensley Street. They confirmed that staff understood what was important to them in relation to feeling safe. We carried out observations in four of the six houses, and found there were periods of time when staff were not present with people in order to monitor their wellbeing and safety. For example, in one house both staff were involved in supporting one person with their morning routines in their bedroom for a period of 25 minutes, meaning that no staff were near the other two people who were in the living room area. In another house we saw that one person's care records showed they should wear a falls pendant, in order to assist them to get help if they fell. However they were not wearing it and staff had not identified this.

We found that staff received regular training in the safeguarding of vulnerable adults, and staff we spoke with could describe appropriate safeguarding procedures. The provider's policy, as well as the local authority's procedures, in relation to safeguarding were available on the premises. We checked records of incidents and found that the provider had taken appropriate action when responding to incidents or accidents to ensure people were kept safe.

We checked five care plans to look at whether there were assessments in place in relation to any risks that people may be vulnerable to, or any that they may present. Each care plan we checked contained up to date risk assessments which were highly detailed, and set out all the steps staff should take to ensure people's safety. We cross-checked this with daily notes, where staff recorded how they had supported each person. However, we found that daily notes were not always detailed enough for us to be able to tell whether staff were providing support in the way set out in order to keep people safe, despite team meeting records evidencing that staff had been instructed to add more detail to these records.

Recruitment procedures at the home had been designed to ensure that people were kept safe., All staff underwent a Disclosure and Barring Service (DBS) check before starting work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. In addition to this, staff provided a checkable work history and references, including from their most recent employer.

We looked at the systems in place for managing medication. We found that staff had received regular training, and one staff member told us that since the last inspection a programme of more frequent assessments to monitor staff's abilities and knowledge around medicines had been implemented. However, we found there were still shortfalls in some areas of medicines management.

Medicines were mostly securely stored, although we noted in one house the medication storage remained unlocked for the hour that we carried out observations. We looked at Medication Administration Records

(MARs.) We found that in some cases staff had not completed the record to state the amount of stock carried forward each month, meaning that there was no accurate record of the amount of stock that the service should hold. One person's MAR showed that they did not receive their medication for three days which the provider told us was due to the pharmacy or GP making an error. MAR charts had gaps in them, meaning that it was not always possible to tell whether medicines had been administered.

Some people had their medicines on an "as required" basis, often referred to as PRN. In most cases we saw that there were detailed protocols informing staff when a PRN medicine should be used and what the outcome should be, although we found that they were absent in some cases. We looked at the central monitoring records for medication errors. We found that these records showed two or three errors were happening each month. We also identified that some of the errors we had seen had not been picked up by the medication error monitoring system, meaning that managers did not have an oversight of the breadth of errors.

Requires Improvement

Is the service effective?

Our findings

We spoke with one person about the food they had at Wensley Street They told us that the food was enjoyable and always what they liked. Another person told us how they enjoyed preparing their meals. We saw a photo book which contained recipes the person liked, with photos of them preparing these meals.

We checked six people's care records to look at information about their dietary needs and food preferences. Each file contained up to date details, including screening and monitoring records where people were at risk of poor diets or malnutrition, or where people needed specific support around dietary needs. Where people needed the support of external healthcare professionals in relation to nutrition and hydration, appropriate referrals had been made.

The majority of staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Care records we checked showed conflicting information about consent and capacity, and did not provide evidence that the provider was complying with the MCA. One person's care records indicated that they had capacity to consent to all aspects of their care and treatment, but there was little evidence that their consent had been sought. Another person's file contained a range of mental capacity assessments, in which the provider had taken steps to assess whether the person had capacity to make certain decisions, however, they had not been fully completed and there were no conclusions reached, meaning that the provider did not hold information about the person's ability to consent or make decisions. One person's file showed that a mental capacity assessment had been carried out to assess whether the person could make a decision about spending a sizeable amount of money on Christmas presents. The capacity assessment concluded that, as the person had picked the same presents from pictures on three separate occasions they therefore had the capacity to make this decision. However, elsewhere in their file was an assessment setting out that the person had no concept of the value of money, and the capacity assessment relating to Christmas expenditure had failed to take this into account.

Where people lack the capacity to make decisions about their care, the MCA code of practice sets out that decisions should be taken in their best interests, consulting people who know them well, taking into account the person's views where known, and ensuring the decision taken is the least restrictive option. We found that there were records in some people's care files showing that best interest decisions had been taken, however, they were not always reached in line with the MCA. For example, one person who had family involvement in their care and wellbeing, had best interest decisions where their family had not been consulted. Another person's file showed that they had an advocate, but there was no evidence their advocate had been involved in reaching best interest decisions. Some people, who lacked capacity, had

specific care interventions for which no best interest decisions had been reached.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The staff members we spoke with told us there were frequent training opportunities available at the home. We checked a sample of the service's training records and found that staff had received training in safeguarding vulnerable adults, medicines management, moving and handling, food hygiene and many other areas relevant to meeting the needs of people using the service. Where appropriate to meet people's specific needs, staff had received training in diabetes care and epilepsy care. The majority of staff held a nationally recognised qualification in care.

Requires Improvement

Is the service caring?

Our findings

We asked two people using the service whether they found the staff to be caring. They both replied positively. One said: "I like them [the staff] all good." Another said: "I like all the staff, the manager and the team leaders."

We asked two people using the service about how involved they were in making day to day decisions about their lives. One person told us they had chosen to change their daytime activities as this suited them better. Another told us they undertook activities they liked and told us about examples where staff had helped them find things that interested them.

We carried out a Short Observational Framework for Inspection(SOFI) in two of the houses. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Using SOFI, we found that staff did not always take the time to engage with people in a meaningful or enabling manner. During one SOFI, we observed that although a staff member ate some food while sitting next to one person on a sofa, they did not engage them in conversation and only spoke to the person when the person initiated conversation. During the one hour period that we undertook this SOFI, staff only spoke with this person when they spoke to staff first.

Throughout this SOFI, the two staff predominantly spoke to each other about issues that did not relate to people using the service, and did not take steps to involve people. One person's care plan showed that staff needed to talk with them in a slow and clear way to enhance communication and ensure the person was able to understand. We did not see staff taking these steps, and instead saw that staff communicated with the person in ways that they appeared not to understand, calling at them from another part of the room and asking several quick questions in a row. The person did not respond to the questions staff had asked them, whereas we had observed that the person could comprehend and respond when questions were asked or conversation was initiated in the way set out in their care plan. This meant that staff were isolating the person by not using appropriate communication methods.

In another SOFI, we observed that staff told one person they would bring them an "activities book" which we were told was a photo book to assist the person in choosing that day's activities. We saw that there was a 35 minute period between the staff member telling the person they would do this, and them providing the book. During this time there was no further interaction with the person, and instead they sat in the living room area with no stimulation or engagement. This person's care records contained an assessment which stated that they liked "to sit with staff and laugh and joke" but we did not observe staff engaging with the person in this way throughout the hour that we undertook the SOFI for. This meant that the person was not receiving support in the way they had been assessed as requiring, and was at risk of psychological isolation.

One person asked staff to assist them in tying their hair back. Both staff said that they could not do this, and said to the person that they would take them to another house where there were "girls working" (sic.) This meant that the rota had not been designed to ensure that staff could meet people's needs.

We looked at how staff ensured people's dignity and privacy was upheld. We found that in many kitchen areas there was information on display about people's dietary needs, including risk assessments and information from external healthcare professionals. This did not protect people's privacy. During the inspection we observed an external healthcare professional visited one of the people using the service. The staff on duty conveyed confidential health information about the person to the visiting professional in the communal area with other people present. Again this failed to uphold the person's privacy or dignity.

We looked at how the service met people's cultural and spiritual beliefs. Four of the files we checked recorded that the person had a religious belief, but only one of the files contained information about the steps staff should take to support the person in upholding and practising their beliefs. We found team meeting minutes which said that one person had recently chosen to stop practising an aspect of their religious tradition, but there was no information in their care records about this.

Staff had a good understanding of people's individual needs and preferences, and could speak with knowledge and in detail about each person using the service, however, we found the level of personalisation in people's care plans varied. For example, people had very personalised documents setting out their preferences in relation to daily care and goals, amongst other areas. However, we found that some documents had been "cut and pasted" meaning that four of the assessments we looked at in relation to how people managed their money were identical with changes being made only to reflect the person's name. In some cases records held a name, or gender pronoun, which did not reflect the person they were describing. Another person had a document in their file setting out the type of support they needed which referred to them as "xxxx" throughout. This meant that some parts of people's care planning was not person centred and instead was generic, failing to reflect the independent, choice led ethos of supported living.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Good

Is the service responsive?

Our findings

Staff told us that people were able to participate in a wide range of activities, with the focus being on people making decisions about what they wanted to do, rather than organised formal activities within the service. People told us they enjoyed taking part in activities both in the home and within the community. One person told us they had recently had a birthday party in their home, and showed us they had planted flowers in their garden with staff support.

There was a high level of community involvement for people using the service. On the day of the inspection several people were going out, including accessing a cooking group, day centres and other community facilities. Records showed they frequently attended local social groups and other community facilities.

We checked care records belonging to six people who were using the service at the time of the inspection. We found that care plans were highly detailed, setting out exactly how to support each person so that their individual needs were met. They told staff how to support and care for people to ensure that they received care in the way they had been assessed. This was linked to a goal programme, where people set targets and goals. One person told us that they had set a goal to go to a nightclub and staff had recently facilitated this.

Care records showed that people's care was formally reviewed regularly to ensure it met people's needs. Where required, changes were made to people's care as a result of these reviews. We looked at people's daily notes, which is where staff recorded the day to day support that people had been provided with. We found that they often lacked detail, with staff making entries such as "morning routines followed" or "all care tasks carried out." This did not give sufficient information about the care and support that had been provided, meaning that there was a risk that when care was reviewed the reviewer did not have an adequately detailed picture of the person's wellbeing or any issues during the review period.

There was information about how to make complaints available in the home, and a complaints policy. There had been no formal complaints received in the year preceding the inspection. We asked one person using the service what they would do if they wanted to complain about anything, and they told us they would be confident to raise any concerns with the registered manager.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager, as required by a condition of its registration. The registered manager had been in post for several years, and was supported by a deputy manager and a team of team leaders, as well as by a regional manager. The provider was displaying their most recent rating in both the office area and on their website, as required.

In recent years, the service had transitioned from being a "care home." This meant that in the past accommodation and support had been provided as one package. The service was then remodelled to a "supported living" service, meaning that people using the service had individual tenancies and more control over how their care was provided. The provider was responsible for the provision of care only. We inspected the premises but found there was limited evidence of the ethos of supported living. For example, there were memos and notices for staff information on display in people's living rooms. In one of the houses there was a notice on display for staff telling them that all food storage areas should be locked when one person using the service was at home. We found that these areas were locked despite the person not being at home. This showed that the person –led, independent ethos of supported living was not being facilitated by staff or the provider, minimising choice and reducing the opportunities for people to exercise their own agency.

There was a supervision and appraisal programme in place, and we saw that staff had regular supervision with a nominated manager. The supervision meetings were used to discuss any staff performance issues, staff development needs and wellbeing, as well as any issues regarding people using the service. Staff we spoke with told us they felt well supported by the registered manager and the provider. The provider had a programme for recognising individual staff's contribution to the service.

We checked records of recent team meetings and saw that they were used to discuss people's wellbeing, training, policies and procedures and safeguarding. We noted that the team meetings had been used to discuss the expected CQC inspection to ensure that staff were familiar with the kind of information CQC would require. In these discussions staff were advised to be aware of the "best" care plans and to offer these to CQC inspectors for inspection. It was concerning that this indicated the management team believed some care plans were not of a standard that they would wish inspectors to see.

The service's management team carried out a range of audits to ensure the home was operating safely and effectively. This included audits of care plans, checks of health and safety and infection control and audits looking at people's finances. We found that these audits did not always identify and address shortfalls and concerns. For example, one audit of finances found that several days before the audit a calculation error had been made, meaning that the amount of money held did not reflect the amount shown on the records. The audit had rectified this, but there was no evidence of any action been taken in relation to staff who had, for several days, signed a handover record confirming the amounts as checked and accurate when in fact they could not have checked them. Likewise, the medication audits had failed to identify the recording and administration errors we had identified during the inspection.

In addition to the in- house audits, there was a comprehensive audit undertaken by senior management on

a monthly basis. This looked at a wide range of aspects of service delivery, but again had failed to identify the concerns and shortfalls we had found during the inspection. For example, this audit included a check of care records, but had not identified the concerns in relation to care plans which had been "cut and pasted" or the absent mental capacity assessments and best interest records. This meant that the audits undertaken at the service were not fit for purpose.

This is 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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people's care was consistently personalised and tailored to their needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate systems in place for obtaining consent, or for making decisions on behalf of people who lacked the capacity to consent.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess and monitor the quality of care provision.