Southside Partnership

Wardley Street

Inspection report

2 Wardley Street
London
SW18 4LU

Website: www.certitude.org.uk

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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

Wardley Street provides respite care and support for up to seven people with learning disabilities. The service provides respite care for people usually living at home with family but sometimes within Shared Lives care to provide some respite for carers. People typically stayed over a weekend or for a week. There were six people using the service at the time of the inspection, four respite and two emergency placements.

At the last inspection, the service was rated Good.

At this inspection we found the service remained Good.

There was a new manager at the service who had submitted an application to become registered. 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.

Relatives praised the caring attitude of staff. They said their family member enjoyed going to stay at the service and they were satisfied they were well looked after whilst they were there. They said the service kept them regularly updated about any changes during the stay. We received similar comments from health and social care professionals. Care workers were aware of people's preferences, their likes and dislikes and how they liked to spend their day.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to live independent lives and continued to enjoy the activities they participated in whilst at home during their respite stay at the service. People were encouraged to help staff with daily chores such as their laundry or help prepare meals if they wanted to.

People continued to be supported to take their medicines on time, staff completed medicine administration record (MAR) charts when they administered medicines to people. People's healthcare needs were met by the provider, referrals were made when required and specialist support plans were in place to support people for health conditions such as epilepsy. People were supported in relation to their eating and drinking

support needs.

Staff told us they felt supported and worked well together as a team. New staff received a thorough induction in the minimum accepted standards expected of care workers and also into the values and behaviours expected of them. Staff received regular training, supervision and appraisal.

The provider carried out an assessment of people's needs and their risks before they came to use the service. This meant that the provider had appropriate information to support people. Individual care plans were in place for each person. Care plans included a personal information and contact sheet, support plans, professional guidance and end of stay reports. End of stay reports included social and recreational activities that took place, if there were any health concerns, behavioural issues and night reports. This was given to carers when people went back home.

Care plans were person-centred. A person centred profile was available giving information about how best to support people, their qualities and important things to them. People's communication, cultural and spiritual support needs were included in care plans.

People were given information about their care and support in a format that was easy to understand. Pictures of staff were on display in the entrance to the service, menus were available in a pictorial format and cupboards were labelled with their contents.

There was an open culture within the service with an emphasis on support and transparency. Quality assurance and governance systems were effective and used to drive continuous improvement. Debriefs were held demonstrating the providers commitment to on-going learning.

The service enabled and encouraged open communication with people who use the service, those that matter to them, staff and other stakeholders. The service worked in partnership with key organisations, including the local authority to support care 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? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service was Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Wardley 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.

This was a comprehensive inspection and took place on 31 October and 1 November 2017.

The first day of the inspection was unannounced, the provider knew we would be returning on the second day. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke briefly with one person using the service, we were not able to speak with others as we were not able to communicate with them verbally. We also spoke with the head of service, the deputy manager and four care workers.

We checked records related to the management of the service. These included three care plans, four staff files, training records and audits.

After the inspection we spoke with five relatives over the phone of people who were regular users of the service. We also contacted five health and social care professions and we heard back from four of them.

Good

Our findings

Relatives told us the service was safe and they felt content leaving their family members there, knowing they would be looked after. Comments included, "They look after him/her", "She/he's looked after very well. They accommodate him/her well", "Definitely happy and settled" and "She/he loves going there now. She/he likes the staff."

Staff were familiar with safeguarding reporting procedures and were aware of possible tell-tale signs of abuse. They said, "Safeguarding is protecting people from harm. I would notify the safeguarding lead, there's a number in the office for the safeguarding team if the manager is not around", "I would look out for sudden change in behaviour or unexplained injuries or marks", "Because there is a risk of harm I would have to notify the manager if someone told me they were being abused." Training records showed that staff had received safeguarding training. The provider notified the relevant authorities where concerns had been raised and worked with them to try and prevent similar occurrences in future.

Risks to people were assessed and recorded in risk management plans. These recorded what the risk was, what needed to be done to keep people safe and what steps needed to be taken if things went wrong. Moving and handling risk assessments included information about unsafe practices which were not to be used and how to support people with walking, standing and bathing. One person did not have a risk management plan in place, we highlighted this to the head of service who found the record on the computer on the second day of the inspection. People had a Personal Emergency Evacuation Plan (PEEP) which included information about their mobility, sensory/communication needs and an agreed evacuation strategy for the day and the night.

Checks to monitor the safety of the environment were carried out on a regular basis. These included daily and weekly checks which looked at the internal environment for any issues relating to areas such as lights, cleanliness, hot water temperatures and fire safety. We saw up to date certificates for gas safety, electrical safety, and portable appliances. Where issues had been found these had been rectified. For example, we saw an engineer report for a defective profile bed which had subsequently been repaired.

The provider had robust recruitment procedures in place. The Human Resources department was responsible for completing all the required pre-employment checks such as right to work, identity and references. Each staff member had a current Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. There were enough staff to support people. Some people were assessed as needing one to one staffing provision

for the duration of their stay which was provided.

People were supported to take their medicines. A relative told us, "They always fill out the medication chart, they are very good." People that needed to take medicines were expected to bring these in at the beginning of their stay. Medicines were counted at the beginning and the end of their stay. We counted medicines to be correct. Staff completed medicine administration record (MAR) charts for the duration of people's stay. People on PRN ('when necessary' such as painkillers) medicines had PRN guidelines in place. Where people had crushed medicines, guidance from the GP was included. We spoke with the provider about seeking approval from the pharmacist regarding crushed medicines and they took our feedback on board and took action to address this. After the inspection we were contacted by the head of Service who confirmed pharmacist approval had been sought.

Good

Our findings

People using the service were supported by staff who received regular training to enable them to meet people's needs effectively.

Induction for new staff included a day where they had an opportunity to meet a person using the service and were introduced to the organisations values and behaviours. They also agreed the key skills and behaviours to be demonstrated, key objectives to be achieved and the training to be attended. Staff had a six week probation period, with a midterm review at three months and an end of term review at six months to check if their targets had been met. New staff completed the Care Certificate as part of their induction. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. New staff completed three workbooks as part of this. Once the workbooks had been completed and signed off by the manager, they were monitored by the training department who checked the quality of the work.

A training matrix was used with a RAG (red, amber, green) system to monitor the last time staff attended training and when it was due to be refreshed. This provided a clear, visual indication of with the number of months left for the training to expire. Mandatory training included manual handling, moving and positioning, medicines, first aid, fire awareness, health and safety, safeguarding, equality and diversity and person centred care.

People continued to receive care and support from staff that reflected on their working practices. Staff files contained evidence of their annual reviews and supervisions. The annual reviews looked at current performance, skills and career development and future objectives. Supervision topics included any outstanding actions from previous meetings, training and areas for development.

Relatives said they were satisfied with the support their family members received with regards to their meals. Menus were planned in advance and the preferences of people were taken into account. The menu for the week of our inspection included curry, pasta bake, pies and a stir fry. People's allergies and preferences were on display as well as their cultural and religious requirements. The kitchen was well stocked with food. Opened food was labelled with the date it had been opened and when it was due to expire. Food cupboards were labelled for easier identification if people wanted to help themselves to anything.

People were supported to maintain good health and had access to appropriate healthcare professionals if needed. A relative explained how the service had worked in worked with the community Occupational Therapist (OT) to provide better support for their family member. A staff member said, "[Person's] needs had changed, we contacted the OT to come in as his/her mobility had deteriorated."

Health needs were documented and how staff could support them in relation to their sight, hearing, maintaining a healthy weight amongst others. Each area of need included the support that staff needed to give to help the person.

We saw records detailing people's support needs and care plans included support guidelines from professionals such as a clinical psychologist. These contained detailed information about how to support people and strategies to manage incidents of behaviour that challenged. Specialist support plans for epilepsy were in place and included information about the type of seizure, how often they occurred, any patterns, triggers, the duration of seizures, recovery, action to take, and a record sheet.

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 saw evidence that the principles of the MCA and its uses were discussed in team meetings and learning days. Staff also demonstrated an understanding of its use. One staff said, "MCA was incorporated in a team meeting. We had a workshop and a quiz." Another said, "MCA is used to ensure adults who cannot make certain decisions are supported properly, they need to be assessed for capacity."

Staff understood issues around consent and were aware of the importance of seeking and respecting people's right to choose how they wanted to be supported. One care worker said, "If people refuse to take their medicines or be supported, I would respect their decision but try and encourage them." People were supported to lead independent lives, one staff said, "I help them to go out to their activity of choice." Another said, "[Person] is autistic so if she/he doesn't want to do something, they offer alternatives and give him/her the iPad or they give him/her a bath.

Good

Our findings

Relatives praised the caring attitude of staff. Comments included, "Staff are very caring. She/He comes back happy", "I'm very happy, staff are kind", "The carers seem good, friendly and caring. I can ring them up anytime, never had any trouble" and "She/he's really happy there. She/he loves going there so much that she/he goes straight in and into his/her room. We can tell by his/her body language she/he's happy."

Arrangements were in place to ensure that, where they were able to, people and their relatives were involved in making decisions and planning their care. Relatives told us they felt listened to, respected and had their views and those of their family member acted on. This was through regular meetings. Relatives told us, "I go to the quality carer meetings", "We attend the carers meeting, we can all be together and talk about issues. It's good to have other people asking questions. They have improved on the issues that people raised", "We attend the carers meetings every three months. I've also requested minutes get sent so I can keep track of any actions. If they can rectify anything immediately they do it."

People's independence was promoted. Each room had a sink, lamp, single bed and a TV. The rooms on the ground floor had profiling beds and walk in shower rooms. There was a lounge on the ground floor attached to a kitchen/dining room and a smaller lounge on the first floor. A laundry was on site and people who were independent were able to do their own laundry if they wished. A relative told us, "She/he does help them, she/he helps to wash and dry and laundry folding which she/he likes. They've incorporated that into his/her timetable."

Staff said, "We take a person centred approach. We respect people's independence and right to have their own opinions", "People have different needs, some are more independent than others", "If people show an interest, we encourage them to help with peeling and washing up."

People were given information about their care and support in a format that was easy to understand. Pictures of staff were on display in the entrance to the service, menus were available in a pictorial format and cupboards were labelled with their contents. People's communication support needs were included. These included how people could communicate effectively with the person, how they understood other people, how they got their message across and do's and don'ts. We saw staff following this guidance for one person when they were supporting them.

Care plans were person-centred. A person centred profile was available giving information about how best to support people, their qualities and important things to them. Care workers were aware of people's

preferences, their likes and dislikes and how they liked to spend their day.

The provider held parties to celebrate festivals and events throughout the year. At the time of the inspection the home was decorated with Halloween memorabilia. Cultural and spiritual needs were included in care plans. Staff were aware of the importance of respecting cultural needs and treating people with respect. Comments included, "Equality is to treat people equally and without bias and discrimination", "You have to stay within the limits that people set. Some people are happy for you to support them with personal care and others are not", "Regardless of people's views you still treat them with respect but make management aware."

Good

Our findings

A thorough assessment procedure was in place which helped to ensure the service was appropriate for people. Some people used the service on a regular basis as their carers were allocated a certain number of respite days. The service also had provision for some people that needed a place to stay in an emergency whilst a permanent placement was sought for them.

The provider sent out booking forms to social workers requesting respite. This booking form requested information about why the referral had been made, their support needs, risk assessments and outcomes to be achieved. The provider also requested any extra information such as day centre reports, any current risk assessments or care plans to help them make a decision and also to provide them with as much information as possible about the person before they came to the service. The provider then developed their own care plans when people came to the service. The manager or deputy manager made a decision based on the requirements as stipulated on the booking form.

People were given the opportunity to visit the respite service beforehand and familiarise themselves with the staff and the environment.

Care plans included a personal information and contact sheet, support plans, specialist support plans such as epilepsy support plans, other information or professional guidance, daily handover sheets and end of stay reports, night reports and medicines records. A flash sheet containing basic information about the person, important contact information and details of health professionals involved in their care was included.

Staff members were given a caseload of people to support and be responsible for ensuring their care and support plans were up to date. At the end of their stay, their key worker produced an 'end of stay report'. End of stay reports included social and recreational activities that took place, if there were any health concerns, behavioural issues and night reports. A relative said, "The end of stay report is helpful."

We received positive feedback from health and social care professionals' about the service. Comments included, "Wardley street effectively and proactively support people that require positive behavioural support and are experienced at supporting individuals on the autistic spectrum", "Very particular about the necessary paperwork and keep in touch with carers about residents needs should they be changed" and "Staff at Wardley street will request meetings to look at the needs of service users they have concerns around, meeting the needs in order that a plan of agreed action can be drawn up as swiftly as possible."

Care plans included details of activities that people enjoy from those that were essential, to routines, likes and dislikes. Relatives told us, "They go out for dinner, they play games with her", "We had three conditions that we wanted from respite. [Person] had a quiet room, she/he goes out every time weather permitting and she/he had a remote control and they have met these. She/he's been cinema, shopping centres, meals, bus journeys. She/he always goes out."

Staff told us the majority of people that stayed during the week attended a day centre. At the time of our inspection, only one person was at the service. The rest were out in the community. Staff said they tried to ensure people continued with their daily routines whilst they were in respite to minimise any disruption to their daily lives. However, people were given the choice to do any of their usual activities or stay at the service.

Relatives told us they did not have to raise any formal complaints but when they had concerns, they knew who to speak with and, when they did, the provider listened and acted upon their concerns. Comments included, "I will let them know if I'm not happy and I'm sure they will act", "The staff have rectified things we have raised" and "Very willing to listen and act upon complaints." Formal complaints were recorded on a database. We checked this and saw there had been no formal complaints received. The deputy manager told us that they usually dealt with complaints as they came in and they tended to be issues that could be resolved fairly quickly.

Good

Our findings

Staff told us, "The team spirit is good", "We work hand in hand and do things together" and "Really enjoy working here, I love it."

There was a new manager at the service who was applying for the post of 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 2008 and associated Regulations about how the service is run.

There was an open culture within the service with an emphasis on support and transparency.

One health and social care professional said, We have a close working relationship with Wardley Street in terms of sharing information and will usually have contact with Wardley Street during a person's stay to share any relevant information. We work collaboratively to support carers to garner information to ensure the reliability of the service."

The provider submitted statutory notifications to the Care Quality Commission (CQC) for incidents that were notifiable and shared outcome of the investigations with carers. There was evidence that the provider acted proactively in acting on complaints and safeguarding concerns that had been raised with them.

In response to one incident the provider arranged a learning day around incident reporting and learning from these. Staff received feedback from managers in a constructive and motivating way that meant they knew what action they needed to take. Part of this included discussing the incident with staff and asking for their input about where improvements could be made to the reporting process to minimise similar incidents occurring in future. The day also included training on good writing guidance and reports. Following the learning days, actions were identified for follow up. A staff member said, "We had a team day at the head office, talking through issues. I found it interesting."

Debriefs were held demonstrating the providers commitment to ongoing learning. A medicines debrief had been held for staff after a medicines error.

The service enabled and encouraged open communication with people who use the service, those that matter to them, staff and other stakeholders. The service worked in partnership with key organisations,

including the local authority to support care provision.

Relatives told us, "We know [the deputy manager] very well. We go to the meetings and they keep us informed", "The managers listen", "The manager is good, knows how to deal with any problems. They do a good job, we are happy with the service. I don't know what I would do without the service." A 'league of friends' committee had been established which consisted of carers and ex-carers who were involved in fundraising for the service through street parties and other events.

A forum called the Quality Action Group (QAG) met every two months. This consisted of family carers, the managers of the service, commissioning managers and a league of friends committee. The group met to discuss the service and drive improvements. The provider acted on feedback received and had actions in place to try and improve any identified areas including arranging training, improving communication books and food.

Following the last meeting feedback was given regarding the provision of activities and trialling a new booking system. Before the new booking system was trialled, a feedback form was sent to all relevant parties to get their feedback and a consultation meeting was held regarding the new booking system. Other minutes seen documented discussions about the environment, fundraising and what areas needed improving such as activities, improving communication, end of stay report quality and food.

Minutes were available in an easy read format, so they were accessible to people using the service. The meeting minutes were shared with the carers so that those that weren't able to attend had access to them.

Initiatives were in place to see how the service could be improved. In team meetings the 'Quality of Life' project was talked about. A new project trialling a new way of getting information about people that gives them goals to aim for and supporting people to get the most out of their stay.

Quality assurance and governance systems were effective and used to drive continuous improvement. The manager completed a monthly checklist looking at health and safety, fire safety, environmental, shift plans, medicines audits including records and storage, support records, staff records. Regular staff team meetings were held. These included good news stories, activities and roles and responsibilities. Issues raised at QAG meetings were fed back to staff and actions for staff identified. Residents, relatives and staff surveys were sent out. These were available in an accessible format. The most recent survey results had not been fully analysed at the time of our inspection but we saw the feedback and saw that it was generally positive.

A meeting was held every quarter with the manager, senior manager, commissioners and carers; looking at key achievements and good news which evidenced areas such as medicines storage, equipment, challenges faced such as the booking system, actions to increase occupancy, staff training, safeguarding and placements. We saw that plans were in place for the upcoming quarter to increase technology provision to make the service more appealing for younger people, to provide a sensory garden and a pool table.

A member of the quality team and manager from another service visited the service to complete the annual service audit. This was an unannounced visit to go through key areas looking at a sample of files. They rated areas such as the quality of support records, staff records, the environment, health and safety, medicines, finance and the overall quality of service provision. We compared the scores from the September 2017 and the September 2016 audit. We found that although the support record scores had decreased, all the other areas had improved and so had the overall rating.

There was strategic overview by the provider. A quarterly performance report looking at progress against KPI

targets such as workforce, service quality and safeguarding alerts was produced. A monthly operational KPI report was produced reporting on various areas such as staff sickness, agency use, training, annual reviews for staff, support plans, risk assessments, incidents and safeguarding.

The day-to-day culture of the service, including the attitudes, values and behaviour that were expected of staff were discussed.

The culture and values of the service were explained to all staff during their induction. There was a continuous service improvement plan which included some team objectives/pledges that had been made. These included creating an environment to provide excellent respite care, to provide a community based house which offered a supportive environment, encouraging people to gain new experiences and interests, providing a person centred service for every individual, promoting social inclusion and working in close liaison with the full network of services. The team objectives were to increase the amount of day trips especially at weekends, to introduce an activities meeting and to make sure activities are risk assessed. The plan also included next steps, a target date for completion, how success would be measured and how progress would be reviewed.