Halton Borough Council

Halton Adult Placement Service-Adults and Community complex needs division

Inspection report

Halton Adult Placement Service
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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Summary of findings

Overall summary

This inspection was announced and took place on the 18 January 2016. A second day of the inspection took place on 19 January 2016 in order to gather additional information.

Halton Adult Placement Service was previously inspected in December 2013 when it was found to be meeting all the regulatory requirements which were inspected at that time.

The Halton Adult Placement Service is part of Halton Borough Council (The Provider). The service is coordinated from an office located in the grounds of Runcorn Town Hall.

The service currently provides personal care and support for 62 adults with a range of needs. This includes older people (some of whom have dementia) and people with learning and / or physical disabilities who live within the Halton district.

The main use of the service is for day care however ten people receive respite care.

At the time of the inspection there was no registered manager at Halton Adult Placement Service. 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.

A divisional manager and the manager of the service were present during the two days of the inspection and engaged positively in the inspection process.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found that recruitment records were incomplete and did not provide sufficient assurance that people were being cared for by staff that were suitable to work with vulnerable people.

We found that carers had not completed all the necessary induction, core and specialised training relevant to their roles.

We found that the registered person had not established or operated effective systems or processes to assess, monitor and improve the quality and safety of the services provided (including the quality of the experience of service users receiving the service).

People who used the Halton Adult Placement Service or their representatives spoke highly of their experience. All the people we spoke with told us that they liked their carers, got on well with them and looked forward to time with their adult placement link carer.

Likewise, all the adult placement carers we spoke with and met showed a genuine interest and affection for the person or people they cared for and a commitment to providing a person centred service.

Systems had been established to respond to suspicion or evidence of abuse and to complaints or concerns.

Staff spoken with confirmed they promoted healthy eating and monitored any changes in the wellbeing and needs of people they cared for on an ongoing basis. Food safety, nutrition and hydration guidance had also been developed for adult placement carers to reference.

Procedures were also in place to liaise with family members and to arrange GP call outs and initiate referrals to health and social care professionals when necessary.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005. We noted that the provider had developed corporate policies and procedures to provide guidance for staff on the MCA and Deprivation of Liberty Safeguards (DoLS).

Training records viewed did not include any details of training in the MCA. Furthermore, adult placement carers spoken with reported that they had not completed training in this protective legislation. We found no evidence that decisions were made on behalf of people that lacked capacity without reference to the MCA framework.

Summary of findings

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 was not always safe.

Recruitment records were incomplete and did not provide sufficient assurance that people were being cared for by staff that were suitable to work with vulnerable people.

The medication policy was in need of review and medication records viewed did not adequately protect people from the risks associated with unsafe medicines management.

Requires improvement

Is the service effective?
The service was not always effective.

Systems for induction, core and specialised training relevant to the needs of people using the service were in need of review to ensure staff complete all relevant training relevant to their roles and responsibilities.

Staff were aware of the need to promote people using the service to have a healthy lifestyle and to maintain hydration and good nutritional intake.

Systems were also in place to liaise with GPs and to involve other health and social care professionals when necessary.

Requires improvement

Is the service caring?
The service was caring.

Adult placement carers treated people well and they were kind and caring in the way that they provided care and support.

People using the service were treated with respect and their privacy and dignity was maintained.

Good

Is the service responsive?
The service was responsive.

Care records showed people using the service had their needs assessed, planned for and reviewed periodically.

People received care and support which was personalised and responsive to their needs.

Good

Is the service well-led?
The service was not always well led.

The service did not have a registered manager in place at the time of our inspection to provided leadership and direction.

Requires improvement

Summary of findings

Systems to assess, monitor and improve the quality and safety of the service provided by Halton Adult Placement Service were in need of review and development, to safeguard the welfare of people using the service.

The provider had not always notified the CQC of any abuse or allegation of abuse in relation to people using the service.

Halton Adult Placement Service-Adults and Community complex needs division

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 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.

The inspection took place on 18 January 2016 and was announced. A second day of the inspection took place on 19 January 2016 in order to gather additional information. The provider was given 48 hours' notice of our intention to inspect the service. This is in line with our current methodology for inspecting domiciliary care agencies.

The inspection was undertaken by two adult social care inspectors.

It should be noted that the provider was not requested to complete a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about Halton Adult Placement Service. We also looked at all the information which the Care Quality Commission already held on the provider. This included previous inspections and any information the provider had to notify us about. We invited the local authority to provide us with any information they held about Halton Adult Placement Service. We took any information provided to us into account.

During the site visit we spoke with the manager of Halton Adult Placement Service, the divisional manager and three adult placement workers who provided assistance to the inspection team. We also contacted 19 people using the service, 12 relatives and 12 adult placement carers by telephone and undertook home visits to speak with two adult placement carers and review records by invitation. An adult placement worker is employed by Halton Borough Council to assist in the coordination of the adult placement service. Likewise, an adult placement carer is self-employed and provides personal care to people using the service in the carer's own homes.

We encouraged people using the service to communicate with us using their preferred methods of communication.

We looked at a range of records including nine care plans belonging to people who used the service. This process is called pathway tracking and enables us to judge how well the service understand and plan to meet people's care needs and manage any risks to people's health and well-being. Examples of other records viewed included; policies and procedures; four staff files; minutes of meetings; complaint and safeguarding logs; rotas / visit schedules and staff training and audit documentation.

Requires improvement

Is the service safe?

Our findings

We asked people who used the Halton Adult Placement Service or their relatives if they found the service provided by to be safe. People spoken with confirmed that they felt safe. No direct comments were received.

The registered provider had developed a recruitment and selection procedure to provide guidance for management and staff responsible for recruiting new employees.

We discussed the end to end process that Halton Adult Placement Service had developed in relation to the recruitment and matching process for adult placement carers with an adult placement worker. We noted that the process involved: advertisement of posts; shortlisting suitable applicants; (pre-application visits to explain how the service works and to answer queries); submission of an application form; completion of carer assessment reports; production of a summary report by the adult placement worker; initial decision; verification and finally approval by panel.

We looked at a sample of four adult placement carer files for recently recruited staff. We found that two of the files were disorganised and key information was missing from all files including the dates staff had commenced employment. For example, in the first file viewed there was no evidence that a disclosure and barring service (DBS) checks had been completed or that gaps in employment history had been explored. In the second file viewed there was no proof of identification, references or evidence of a DBS. In the third and fourth file viewed there was no proof of identification or evidence of a DBS. The DBS is an organisation that aims to help employers make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups.

We requested to see evidence that DBS checks had been obtained for other adult placement carers and were provided with a matrix. We noted that there were no DBS details recorded for 13 adult placement carers although details of DBS checks had been recorded for the four files sampled.

The management team reported that the information had previously been obtained in order for applications to be approved by panel however the records could not be located to verify the checks had been undertaken.

This was a breach of Regulation 19 (3) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at the files of nine people who were using the Halton Adult Placement Service. We noted that each person had a basic service user plan which included a risk assessment together with supporting documentation. However, the information viewed was very brief and would benefit from additional information to ensure staff have all the necessary information available to them to identify and control risks.

This information helped staff to be aware of current risks for people using the service and the action they should take to control risks. Copies of the records were held at the office and had been provided to adult placement carers.

Systems were in place to record any accidents and incidents that occurred within the service. However, there was no information on lessons learnt and the records included vulnerable adult concerns. It was therefore not easy to identify accidents and incidents. We raised this issue with the management team who assured us that action would be taken to separate the records.

During telephone discussions and home visits to adult placement carers they confirmed that they would notify all relevant issues to their adult placement workers to ensure any necessary actions were taken to keep people safe and well supported.

The adult placement workers reviewed the health and wellbeing of adult placement carers and completed a basic health and safety checklist as part of their support visit records. This included questions regarding: the servicing of gas appliances; water temperature; electrical safety; smoke and carbon monoxide detectors; safe storage of chemicals; tripping hazards and other safety issues.

At the time of our inspection, 62 people were using the Halton Adult Placement Service for day and / or respite care supported by a team of approximately 30 adult placement carers. Adult placement workers used a day sheet system to plan and allocate day care. In the case of respite care a diary system was used.

The management team confirmed that the service had sufficient capacity to meet the needs of the people using the service and that contingency plans were in place to cover absences. A business continuity plan had also been developed by the provider to ensure the service could

Requires improvement

Is the service safe?

continue to operate in the event of an untoward incident. Likewise, an urgent and emergency shared lives arrangements procedure had been developed to ensure an appropriate response in the event of an emergency.

The registered provider had developed an inter-agency policy, procedure and good practice guidelines to offer guidance to staff on safeguarding adults in Halton. An easy read version and a 'whistle blowing' policy was also in place. Adult protection procedures had also been included within the adult placement carer's handbook.

Discussion with the management team and staff, together with a review of training records confirmed the majority of staff working within the adult placement service had completed 'safeguarding awareness' training.

Management and staff spoken with demonstrated an awareness of the different types of abuse and the action they should take in response to suspicion or evidence of abuse. Staff spoken with also demonstrated a sound awareness of how to whistle blow, should the need arise.

The Care Quality Commission (CQC) had received one whistleblowing concern since the last inspection in December 2013. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right.

We viewed the safeguarding records for the Halton Adult Placement service. These were difficult to analyse as they included information on accidents and incidents as referred to above.

Records confirmed that safeguarding concerns received by the service had been referred to the local authority's safeguarding unit however the Care Quality Commission had not been notified of four safeguarding incidents as required. Records viewed included details of the outcomes of safeguarding referrals and action taken.

A corporate medication policy for the Halton Adult Placement Service had been developed by the provider to offer guidance to adult placement carers responsible for the administration of medication. This was in need of review as it referred to out of date guidance and regulations. A medication procedure had also been included in the adult placement carer handbook.

We telephoned 12 adult placement carers and undertook two home visits. The adult placement carers who were responsible for assisting with medication reported that they had completed medication training however there were some gaps on the training record. There was no evidence available to confirm staff had undergone an assessment of competency in relation to this task to ensure best practice.

The majority of adult placement carers spoken with informed us that they did have responsibility for administering medication and that they would complete a Medication Administration Record to record any medication they were requested to administer. One adult placement carer told us that they had used a diary to record the administration of medication and this was raised with the management team to address.

We were unable to sample many medication administration records (MAR) as they had not routinely been returned to the office for storage on central records. We noted that the storage of medication was reviewed as part of the Health and Safety Checklist by adult placement workers however there was no evidence of effective auditing of medication administration and associated records. We saw an example where an adult placement carer had completed the MAR incorrectly and used a tick rather than sign for the medication administered.

Staff had access to personal protective equipment and policies and procedures and guidance for infection control were in place.

We recommend that the medication policy is updated and that staff responsible for administering medication undertake a medication competency assessment and refresher training if necessary to ensure they understand how to correctly record the administration of medication.

We recommend that risk assessments are developed to provide more detailed information on potential / actual risks and measures to control risks.

Requires improvement

Is the service effective?

Our findings

We asked people who used the service or their relatives if they found the service provided by Halton Adult Placement Service to be effective.

We received positive feedback which confirmed people spoken with were of the opinion that their care needs were met by the provider. Comments received included: "It's lovely here. We have lovely meals, it's interesting and I love it so much"; "My sister has been using the service a couple of years. It seems okay. It has helped us a lot" and "I think it's a wonderful service and very unique."

Examination of training records and discussion with the management team confirmed adult placement carers had access to a range of training that was relevant to individual roles and responsibilities.

However, the training matrix did not include details of any induction training provided and highlighted gaps across a range of areas. A number of adult placement carers spoken with reported that they had not completed all core training or training relevant to the needs of people they supported such as the Mental Capacity Act and dementia care. Likewise, during one home visit we noted that an adult placement carer did not have a suitable care plan in place to ensure an appropriate response to a person who had a history of epilepsy. The adult placement carer also reported that they had not completed any training in epilepsy awareness.

This was a breach of Regulation 18 (1) and (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Systems were in place to identify any training gaps however dates when refresher training was due had not been recorded. We noted that adult placement carers had recently completed refresher training in safeguarding awareness and basic life support.

Adult placement workers spoken with reported that they also had access to a range of training opportunities and received formal supervision at regular intervals. Staff also confirmed they felt supported in their roles and advised that they had attended monthly team meetings. Records viewed confirmed that team meetings and staff supervision had been provided at regular intervals. Support meetings were also arranged periodically for adult placement carers to attend.

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.

We checked whether the service was working within the principles of the MCA. We noted that the provider had developed corporate policies and procedures to provide guidance for staff on the MCA and Deprivation of Liberty Safeguards (DoLS).

Training records viewed did not include any details of training in the MCA. Furthermore, adult placement carers spoken with reported that they had not completed training in this protective legislation.

The management team confirmed that systems were in place to undertake an assessment of mental capacity should this be required and a commitment to safeguarding the welfare of people who may lack capacity.

Staff spoken with confirmed they promoted healthy eating and monitored any changes in the wellbeing and needs of people they cared for on an ongoing basis. Food safety, nutrition and hydration guidance had also been developed for adult placement carers to reference.

Systems were also in place to liaise with family members and to arrange GP call outs and initiate referrals to health and social care professionals when necessary.

Good

Is the service caring?

Our findings

We asked people who used the service or their relatives if they found the service provided by Halton Adult Placement Service to be caring. Feedback received was positive and confirmed people spoken with were of the opinion that the service they received was caring.

For example, comments received included: “The service is brilliant. I couldn’t expect better. It’s like a second home to him”; “I cannot fault the service. They understand her needs and are great with her”; “The service is good. They care for my needs and take me places. They are good people”; “All the helpers are superb. Please pass on my compliments to them” and “The staff are lovely and approachable.”

People who used the Halton Adult Placement Service or their representatives spoke highly of their experience. All the people we spoke with told us that they liked their carers, got on well with them and looked forward to time with their adult placement link carer.

Likewise, all the adult placement carers we spoke with and met showed a genuine interest and affection for the person or people they cared for and a commitment to providing a person centred service.

It was apparent that the assessment of adult placement carers and the matching process of people using the service were working effectively as all parties concerns appeared happy and content with their placements and the support mechanisms provided by the management team and adult placement workers.

Adult placement carers spoken with were able to provide examples of how they promoted the principles of good care practice into their day to day work such as: speaking to people using their preferred name; treating people with dignity and respect; asking people how they wished for care and support to be delivered before offering assistance and promoting independence and wellbeing.

We saw that there were signed agreements in place which detailed the roles and responsibilities of the service and of the adult placement carers. Information on adult placement and the aims and objectives of the service had also been included within the service user guide.

Good

Is the service responsive?

Our findings

We asked people who used the service or their relatives if they found the service provided by Halton Adult Placement Service to be responsive to their needs. Feedback received confirmed people were of the view that the service was responsive.

Comments received included: "I like this service and could never complain about it"; "I'm very happy with everything"; "I use the service twice a week. It's a great service. We play games like dominoes, visit different places and do many things together. The carers are very good."

We sampled nine adult placement care files for people using the service as part of the inspection. We found copies of documentation that had been developed by the provider within each file. Files viewed were set out well and easy to follow.

Files viewed contained: Initial referral forms; adult placement service agreements; medical emergency information; supported assessment questionnaires; service user plans including risk assessments; support plan and summary information; review records; daily record sheets and miscellaneous information.

Records viewed contained basic information on the abilities and needs of people using the service, how these would be met by the adult placement service together with identified risks and control mechanisms. Where practicable, plans had been signed by people using the service, their adult placement carers and adult placement workers. Plans viewed had been reviewed periodically.

The provider had established a process for people wishing to access the service from initial referral to the complex care team to the commencement of the adult placement service. The process involved a referral to the service who in turn undertook assessments and compatibility checks. Following the successful completion of these stages, a referral was then made to the approvals panel for a decision and funding approval. Subject to the outcome of this decision introductory visits were then completed prior to the commencement of the service.

The majority of people using the adult placement service used the provision for day care and were supported to engage in a range of social, leisure and recreational opportunities. People told us that they had engaged in activities such as shopping; art and crafts; board games and visiting local places of interest.

In some instances it was difficult to ascertain what people had done during their time in adult placement or outcomes for people as some daily records viewed provided limited information. Examples were discussed with the management team who assured us that action would be taken to improve record keeping practice.

The registered provider had developed a corporate policy and procedure for handling complaints including an easy read version. Information on the complaints procedure had also been included in the adult placement carer's handbook.

We were informed that complaint records were held centrally. A concerns, complaints and compliments file for the Halton Adult Placement Service was also in place. We noted that no complaints had been received by the service in the last 12 months. This information was also confirmed via an email received from a 'representation and information' officer.

Adult Placement Carers and people using the service and relatives spoken with told us that in the event they needed to raise a concern they were confident they would be listened to and the issue of concern acted upon promptly.

Requires improvement

Is the service well-led?

Our findings

We asked people who used the service or their relatives if they found the service provided by Halton Adult Placement Service to be well led. People spoken with confirmed that they felt the service was appropriately managed however no direct comments were received.

Feedback received from adult placement carers and workers was positive regarding the management of the service. Comments received included: "Since the change of management I feel it has gone much more smoothly. We do get more support now from all the management team"; "The management team are good here" and "I absolutely adore my job and the office staff and management work very hard to support us."

At the time of our inspection the Halton Adult Placement Service did not have a registered manager in place. A manager from another service had commenced responsibility for the management of the service during June 2015 and was in the process of registering with the Care Quality Commission. The manager was supported by three adult placement support workers, a performance manager and an administrator.

The divisional manager and manager of the service were present during the two days of our inspection and engaged positively in the inspection process, together with adult placement service workers and adult placement carers. The management team showed a genuine commitment and drive to deliver a good quality service, as well as a desire to continue to develop the service and address shortfalls. There was a strong belief in the benefits of the shared lives model of service provision and the staff team were keen to promote the service.

We asked the management team to share details of the systems in place to assess and monitor the quality of service provided.

We were informed that the Quality Assurance Team of Halton Borough Council had undertaken a visit during November 2015. This is a monitoring process which is undertaken annually to ensure the service meets its contractual obligations.

We were also informed that surveys / questionnaires had been distributed to adult placement carers during October 2015. The returned questionnaires were not dated and summary reports and action plans could not be located. Following our inspection, we received a summary of the adult placement carers' questionnaires for October 2015, together with an action plan.

There was no evidence that feedback from people using the service or their representatives had been sought. This finding was also noted by the local authority following a monitoring review in December 2015.

Support visits were undertaken periodically by the adult placement staff in addition to telephone support and periodic service reviews. We noted that quarterly audits had not always been completed at the required intervals.

A range of areas were reviewed as part of this audit including: support group meetings; health and wellbeing; training needs; paperwork; activities; safeguarding; medication; health and safety and service user issues. We found issues with training and records management despite this auditing system being in place.

We visited two adult placement carers at home. We noted that carers had been provided with an adult placement carer handbook which contained key information on the service and policies and procedures and that the carers were aware of the likes, dislikes and preferences of the people they supported. Diaries and records relating to the service provided were also in place. We saw examples of different recording systems being used. For example one adult placement carer informed us that she maintained electronic records. Likewise, another adult placement carer told us that she used a diary.

We noted that many records relating to the care provided to people using the service had not been routinely brought to the office for safe storage and monitoring. We requested examples of records be obtained and noted significant variations in the standard and detail of records. We provided examples and raised this issue with the management team during our inspection who assured us that action would be taken to improve the standard of record keeping and the return of records to the office for safe storage.

We noted that there was a need for the manager to develop a comprehensive auditing tool to maintain an effective regular overview of the service and to develop existing auditing systems to ensure accountability. The management team acknowledged this feedback and confirmed that action would be taken to develop and

Requires improvement

Is the service well-led?

improve quality assurance processes for areas such as: the overall service provision; support visits and reviews; medication; file audits, care plans, risk assessments and associated records; health and safety; staff training and staff supervision.

This was a breach of Regulation 17 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014. Systems and processes were not established to ensure compliance with good governance.

Information on the Halton Adult Placement Service had been produced in the form of a Statement of Purpose. This document was in need of review to ensure it contained all of the necessary information outlined in Schedule 3 of the Care Quality Commission Registration Regulations.

A copy of this document together with a service user guide was available at the registered office and had been included within the 'Adult Placement Handbook' for adult placement carers to view.

The registered person is required to notify the CQC of certain significant events that may occur. We found that the provider had not always notified the CQC of any abuse or allegation of abuse in relation to people using the service. We have written to the provider regarding their failure to notify the CQC.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not established or operated effective systems or processes to assess, monitor and improve the quality and safety of the services provided (including the quality of the experience of service users receiving the service).**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that all carers had completed the necessary induction, core and specialised training relevant to their roles.**

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person was unable to provide evidence that the necessary checks and records had been obtained for all persons employed for the purposes of carrying on the regulated activity.**