The Wilf Ward Family Trust

The Wilf Ward Family Trust Domiciliary Care Harrogate and Northallerton

Inspection report

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Date of inspection visit: 2 and 7 December 2015
Date of publication: 19/02/2016

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

Overall summary

This inspection took place on 2 and 7 December 2015 and was announced. The last inspection took place in December 2013 when the service was found to be meeting the Regulations.

The Wilf Ward Family Trust Domiciliary Care Harrogate and Northallerton provides personal care and support to people who have a learning disability. People who receive support live in small supported living services which are staffed according to assessed needs. The organisation

Summary of findings

currently has 14 supported living homes in the area, although not all the people require support with personal care. The aim of the service is to support people to live independently.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. There were good systems in place to make sure that people were supported to take medicines safely and as prescribed.

Risks to people had been assessed and plans put in place to keep risks to a minimum. The provider had effective systems to monitor and learn from any accidents or incidents.

There were enough staff on duty to make sure people's needs were met. The provider had robust recruitment procedures to make sure staff had the required skills and were of suitable character and background.

The majority of the staff told us they enjoyed working at the service and that there was good team work. Staff were supported through training, regular supervisions and team meetings to help them carry out their roles effectively. Staff were supported by an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted. The registered manager had taken appropriate action for those people for whom restricted movement was a concern. Best interest meetings were held where people had limited capacity to make decisions for themselves. People were supported to make decisions and choices for themselves, wherever possible.

People told us that staff were caring and that their privacy and dignity were respected. Care plans were person centred and showed that individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met. People were supported to maintain their health and had access to health services if needed.

People's needs were regularly reviewed and appropriate changes were made to the support people received. People were encouraged to be involved in their support plans and had opportunities to make comments about the service and how it could be improved.

There were effective management arrangements in place. The registered manager had a good oversight of the service and was aware of areas of practice that needed to be improved. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified. The provider made sure that the beliefs and values of the organisation were promoted throughout the service.

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 safe.

There was safe management of medicines which meant people were protected against the associated risks.

Staff were confident of using safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Good

Is the service effective?
The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and relevant legislative requirements were followed.

People were supported to maintain good health and were supported to access relevant services such as a GP or other professionals as needed.

Good

Is the service caring?
The service was caring.

People told us that they were looked after by caring staff.

People were supported to make day to day decisions about the care they received.

People were treated with dignity and respect whilst being supported with personal care.

Good

Is the service responsive?
The service was responsive.

People received personalised care in the way that they wanted. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People were supported to make a complaint or compliment about the service. There were opportunities to feed back their views about the service.

Good

Is the service well-led?
The service was well-led.

A registered manager was in place who had good oversight of the service. Staff told us that management was supportive.

There was a positive, caring culture at the service.

Good

Summary of findings

There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

The Wilf Ward Family Trust Domiciliary Care Harrogate and Northallerton

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 inspection took place on 2 and 7 December 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also reviewed the Provider Information Record (PIR). The PIRis 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.

During this inspection we visited the office and spent time in three homes. We looked at records which related to people's individual care. We looked at four people's care planning documentation and other records associated with running a community care service. This included recruitment records, the staff rota, notifications and records of meetings.

A number of people who used the service were not able to communicate their views. However, we did spend time observing routines and how staff supported people. We spoke with four people who received a service, five members of staff and the registered manager. We also received written feedback from another four members of staff.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe and could speak with staff if they had any concerns. Comments included "I feel safe here. Staff are kind. The manager is nice. If I'm not happy with something I tell the (house) manager and he will do something" and "I feel safe here. The staff make me feel safe". Staff members also felt that the service was safe. One support worker said "People are very much safe" and another commented "We talk to people about safety. We use picture cards to help with this".

Staff were confident about identifying and responding to any concerns about people's well-being. Staff had received safeguarding training which gave them the skills they needed to protect people. One member of staff explained "My training gives me an understanding of safeguarding and protecting people from neglect and abuse". Another staff member told us "Any concerns we have for any of the customers (people who used the service) are reported to the managerial staff who will deal with it using the appropriate procedures". Staff also had an understanding of whistleblowing procedures should they have any concerns about practice within the organisation.

Any incidents were recorded and included details of action taken to keep people safe and prevent a reoccurrence. The registered manager explained that incidents were monitored and any learning was discussed organisationally and reviewed by the service where the incident occurred. There had been no recent safeguarding notifications made to the CQC but staff were aware of their responsibility to do this when required.

There were comprehensive and personalised risk assessments in people's support plans. One manager told us "We believe in responsible risk taking. We support people to go out and do things safely". Risk assessments were clearly written and up to date. They included information about each risk and how risks could be reduced to keep people safe. The service was looking at how to make sure risk assessments were relevant to people's individual needs. For example, a holiday risk assessment had been developed which considered all aspects of people's needs, including risks associated with involvement, choice and mental capacity. This included action points to consider and the date that these were achieved. A similar risk assessment was being developed for personal care. We saw an example of this for one person. The risk assessment considered the potential impact on the person's dignity as well as risks due to lack of involvement, choice and capacity to understand. We noted that this assessment was discussed at every team meeting to review and update as necessary. The registered manager told us that it was planned to use this across the organisation.

Where there were risks associated with people's behaviour there was clear guidance about possible behaviours, triggers and practical strategies to prevent escalation and keep people safe. The organisation operated a 'no restraint' policy which meant they never used physical intervention to manage a situation.

Recruitment records showed that all the necessary background checks were carried out before new staff were able to start work. These included a criminal records check, references and proof of identification. Application forms and interview notes showed how the provider assessed new staff to have the skills and experience to work at the service. We saw that some people who used the service were supported to be involved in interviews. One person had their own list of questions and their support plan included information about how to involve them in recruitment. We were shown evidence of how one applicant was not offered the post based on feedback from a person involved in interviewing. One person confirmed their involvement and said, "A new staff came to look around and I was asked what I thought about them". This demonstrated how the organisation made sure that new staff were suitable to work with the people they were going to be supporting.

There were sufficient numbers of staff on duty to meet people's needs and keep them safe. The staff we spoke with felt that the staffing levels allowed them to meet people's needs. The registered manager told us that if agency staff were used they tried to use the same workers to make sure they were familiar to people who used the service.

There were robust procedures for the safe management of medicines. Each person had a locked medicines cupboard in their room as well as a medication information folder. The folder contained personalised guidelines which included information about how they preferred to take their medicine. One person confirmed they were given medicines in the way they wanted. Guidance included a summary of each medicine and what it was for.

Good

Is the service safe?

Medication Administration Records (MAR) were used to record each medicine, time and dose. MAR charts identified each medicine and were clearly written. There were no unexplained gaps in recording on the MAR charts we looked at. Where people had medicine which was taken 'as required' there was information about when it was needed and the reason for it's use had been recorded.

Staff had received training in the management of medicines and had additional training for any specific areas of medicines practice where needed. For example one person received regular injections and we saw that the responsible staff had been trained in this by a district nurse to make sure they were competent. There was specific guidance for one person who required a patch which was changed weekly. A body chart was used to show where the patch had been applied previously so that it could be placed on a different part of the body each time. This demonstrated how the service made sure medicines practice was safe and in line with current guidance.

The service made sure that where any errors in medicine administration were identified they were investigated and appropriate action taken to prevent future errors. One member of staff told us about an error that occurred in the house they worked in. They said "The error was acted upon in the most professional manner and my manager is currently in the process of updating the procedure so it's clearer and more understandable. She has also tried to reduce the potential for future mistakes such as introducing more checks to ensure the mistake does not happen again".

Good

Is the service effective?

Our findings

Staff told us that they provided effective care and most staff said they felt supported. Staff comments included "We are a really good team. We work well together", "I really enjoy it. I'm happy working here and get a lot of support" and "I feel very supported in my job role. My manager has been very helpful and so have the other members of staff. Everyone has been lovely, friendly, helpful and approachable".

Staff members received a suitable induction when they started working at the service. This included essential core training, shadowing other staff, and time to get to know people who used the service. There was a training plan in place to make sure that staff had the skills they needed to carry out their roles effectively. Training was updated as necessary and included mandatory areas such as moving and handling, medicine management and health and safety. There were opportunities to attend specialist training to further staff development and knowledge. One member of staff explained "There is good training. I recently did a positive intervention course for challenging behaviour". The registered manager explained that they tried to encourage staff specialisms. They added that one house manager had recently completed a degree course in dementia as two people had been identified who needed support in this area.

At one of the houses we visited we saw that an agency folder had been set up. This included photos of agency staff used as well as information about their experience and interests. Agency staff were encouraged to give feedback about their experience of working for the service. The manager of the house explained that this meant they could make sure that agency staff received the support they needed when working at the homes.

Staff were supported to discuss their progress and development. Regular supervisions took place with a manager every six to eight weeks. Records showed that supervisions included discussions about progress, objectives, competency and training. The registered manager explained that they did not carry out annual appraisals of staff, but each supervision looked at what staff were responsible for in their roles and how they were doing it. Objectives and action points were then reviewed at the next supervision.

There were monthly team meetings at each house where staff would get together to discuss organisational issues and ideas. The meeting minutes in one house showed that there were regular discussions about work practice with consideration given to current legislation. For example in November 2015 there was a discussion about CQC requirements as well as good practice to promote people's dignity. One member of staff gave positive feedback about team meetings and told us "These are very professional and informed meetings where staff are able to voice their opinions but we (staff)are also informed of big issues, where there is room for improvement and what we can do to help improve things".

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.

Staff were clear about their responsibilities under the MCA and had received training in this area. Support plans contained very clear and detailed information for each person regarding consent and capacity to make decisions. Each person had a MCA support plan and risk assessment. This gave good, personalised guidance to staff about how to support people with making decisions. It included information about what to do if a person lacked capacity to make a decision and when to complete a mental capacity assessment. Staff were aware of when a best interest meeting would need to be held. A best interest meeting is a meeting of those who know the person well, such as relatives, or professionals involved in their care. A decision is then made based on what is felt to be in the best interest of the person. Where best interest meetings had taken place there was information in support plans about the decisions made and the reason the person lacked capacity for that decision.

Guidance was provided in support plans about Deprivation of Liberty Safeguards and the Court of Protection. This included what action needed to happen if a person was

Good

Is the service effective?

being deprived of their liberty, for example if they lacked mobility or needed constant staff supervision. The registered manager told us that they had requested an assessment for one person who met this criteria.

Where required there was information in people's support plans about their needs in relation to eating and drinking. For example, one person's nutrition support plan described the support they needed with a swallowing difficulty. We noted that guidance had been provided by a Speech and Language Therapist and a dietician had been involved. A choking risk assessment was also in place. Staff who supported this person had been trained in nutrition. This showed that staff were provided with information about dietary needs which meant they could monitor those people where risks were identified.

People were supported to maintain their health and had access to health services as needed. Support plans contained clear information about peoples' health needs. There was guidance about particular syndromes relevant to each individual so that staff had a better understanding of their needs. There was evidence of the involvement of healthcare professionals such as a GP, mental health specialist or community nurse.

Good

Is the service caring?

Our findings

People told us that they were happy with the service. One person said "It's brilliant here. Staff are lovely. And brilliant." Another person when asked if they were looked after by staff replied "Yes". We noted that for one house feedback questionnaires had been received from relatives in November 2015. They all described care and support as "Excellent" or "Very good".

Staff also told us that they thought the service was caring. One house manager said "I believe it is absolutely caring. I always consider if I would be happy for a family member to be here. Care is second to none". Another member of staff commented "People are well looked after. Staff have their best interests at heart. I feel that people are happy".

Although we did not observe personal care being carried out, we did see good, caring practice in all the houses we visited. The atmosphere in each of the houses was friendly and there was a homely feel. Staff were attentive to people's needs and had a good understanding about how best to communicate. The people we saw appeared happy and relaxed in their environment.

People were treated with dignity and their privacy was respected. One person told us "If I'm in my room staff knock before they come in". Staff confirmed that dignity and respect were seen as an important part of the culture of the service. One staff member explained "Everyone in the house has their own room which is their space. Staff do not enter unless asked or permission is granted from the individual. We try to avoid being intrusive whilst still trying to show that we care and will help with anything".

One house manager told us "Privacy and dignity is interwoven throughout induction. There is a privacy and dignity session". They added that a dignity day was being planned for February 2016 and that dignity was regularly discussed in team meeting. The minutes of one team meeting confirmed this and showed that there had been a recent discussion about the principles of dignity in care and how it applied to the service. The promotion of dignity and respect was highlighted throughout people's support plans. For example one person's support plan explained how their dignity could potentially be affected by personal care and gave good guidance about how to maintain privacy and respect.

People were encouraged to make day to day decisions about what they wanted to do and how they received care and support. For example, rather than allocate a member of staff to provide support, people were able to choose who they wanted to help them. A house manager explained "It's always their choice. We are aware of each individual's way of requesting things". A staff member told us "Choices are always given and the answers are respected".

People were also supported to be involved in the service. One person described how they assisted with the recruitment of staff and helped draw up the staff rota for the week. This demonstrated how people were empowered to have a say in some aspects of service provision. Where needed, people received advocacy support to help them have a say and build self-confidence. For example, one person attended a local self-advocacy group.

Good

Is the service responsive?

Our findings

People received person centred care which was responsive to their needs. Care and support plans were detailed, clearly written and focussed on individual preferences. Each person had a one page profile in their support plan which gave information about their background, character, interests and wishes. This gave staff good information about the people they supported and their individual identity. Each person had an assessment of their needs before they started with the service.

Support plans were up to date and showed clear evidence of the involvement of people in what was recorded. One member of staff explained "People are involved in what is written about them. We will observe body language if needed". Another staff member commented "We try to involve people in support plans. Everything we do is for the people". We noted some of the methods which were used to support people in giving their views about the support they needed. These included the use of picture cards, photos, videos, computer tablets and observation.

Support plans contained good information about preferences and approaches for helping with personal care needs. One person's plan included step by step guidance about how to support with bathing. There was also detailed guidance, including photographs of how to assist them with sleeping and getting in and out of bed. Another person had guidance about their personal care routine. This included respecting the person's choices about who they wanted to support them, what they could do for themselves and how to know when they wanted a task to finish. A member of staff explained that preferences were taken into account in all aspects of care. For example, making sure people had the toiletries they wanted.

We noted that support plans emphasised the importance of encouraging independence and developing people's skills. Support plans were reviewed regularly to make sure that any changes in needs were identified and appropriate support put in place. One member of staff told us "Customers' needs are constantly changing and staff are constantly evolving to meet those needs".

People and their relatives were supported to understand how to make a complaint and raise concerns about the service. The registered manager told us that following a survey in 2014 it was identified that not all families knew how to make a complaint. Following this, complaints information was sent out and an easy read version was given to people who used the service. People we spoke with during our visit confirmed this. One person said "I know how to complain. I have a complaints form" and another person told us "I complain about some things. I will talk to staff".

We were shown a welcome pack which was provided to people who used the service. This included a pictorial complaints procedure, as well as contact details of local authorities and the CQC. It was also stated in the welcome pack that people could complain directly to the Chief Executive of the organisation, if they preferred.

One house manager described how the staff team were developing a complaints system for people who were unable to communicate verbally. This was being trialled for one person who was unable to verbally tell staff if they were unhappy about something. The system involved staff observation of the person's behaviour and mood to identify if they appeared unhappy. Where concerns were identified a behaviour monitoring chart was completed throughout the day to record what was happening and consider possible causes in order to try and resolve the situation. It was hoped that in time and through regular use, this would give a clearer picture of what might be affecting the person's mood so that it can be resolved at an earlier stage.

The service kept a record of complaints and compliments received. The registered manager explained that they tried to learn from complaints and any trends were shared with the provider. The log of complaints included details of the action taken in response and any learning which would help to prevent a reoccurrence. For example, consideration of complaints was a regular item for team meeting discussion.

Good

Is the service well-led?

Our findings

Staff were generally positive about the management of the service. Comments included "I'm supported by management. Listened to", "Management are usually supportive of ideas but they like us to evidence why it is needed" and "Any issues which they (management) have the ability to deal with have been done sopromptlyand effectively withthe best interests of the staff and customers in mind". A house manager told us the organisation was "Fantastic to work for. Person centred. They put service users above of everything else. The management structure is great".

The registered manager oversaw 14 supported living houses in the Harrogate and Northallerton area. They were supported by two Deputy Regional Managers (DRM) and each house had a 'home manager' who was responsible for the day to day operation of the service. The registered manager spoke knowledgeably about the service and had a clear understanding of the requirements of the Regulations. They were aware of areas of practice that could be improved and had taken action to make changes where appropriate. For example they told us about improvements made following a recent safeguarding alert. They learnt that the service needed to improve communication with families and has discussed with individual teams about how to do this.

There were suitable systems in place to monitor and improve the quality of care provided. The provider had an audit system which focussed on the CQC domains of Safe, Effective, Caring, Responsive and Well-led. It was clear that the provider had looked closely at the new Regulations and inspection methodology to make sure that they were operating in line with expectations. A DRM visited a service each week to carry out audits, 'walk the floor' and observe practice. There were also quarterly audits in health and safety, staffing and infection control. We noted that there were good systems in each house to make sure that the provider was kept informed about the quality of the service, any incidents and areas that needed to be improved.

The registered manager explained that there were a number of organisational meetings which supported effective monitoring and promoted staff involvement. A staff consultation group had three representatives from the Harrogate and Northallerton and met every month. There were also leadership meetings every two months where issues were discussed at management level. The registered manager showed us a risk assessment tool which was used to monitor organisational risks. This covered areas such as health and safety, data security, safeguarding and regulatory compliance. It included possible risks, the impact on the service and action taken to mitigate risks. We noted that each entry had also considered the impact on CQC expectations. This demonstrated that the provider had a good overview of the service and could effectively monitor risk and areas identified for improvement.

There was a positive, caring culture at the service. Staff demonstrated a commitment to provide person centred care in line with the ethos of the service. There was clear information about the aims and objectives of the service in the Statement of Purpose and Welcome Pack. The provider promoted the values and culture of the organisation through seven expected behaviours of employees called The Wilf Ward Family Trust Way. These values included working together, respecting each other, positive communication and effective leadership. The registered manager explained they were developing a process through which they could evidence these values were embedded throughout the service. Part of this would be to encourage staff to talk about how they work, what they do well and what could be better. They added that beliefs and values were also discussed during interviews and part of supervisions.

The staff we spoke with demonstrated an awareness and commitment to the values of the organisation. One staff member said "There is a culture of care". One house manager told us "The values of the organisation are shared in the Welcome Pack. We have staff development sessions and observation. Staff get an internal award for recognition of work towards CQC domains. Our core values are dignity, personalisation and enablement. We want people to be at the centre".