South Tyneside MBC

Danesfield Supported Living Service

Inspection report

Danesfield
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25 November 2015

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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 took place on 16, 23 and 25 November 2015 and was unannounced. The service was last inspected on 20 November 2014 and met the regulations we inspected against at that time.

Danesfield Supported Living Service provides care and support for 19 people in their own homes including 24 hour care. This includes care and support for people with a learning disability, mental health problems and physical disabilities.

The service did not have a registered manager at the time of our inspection. The registered manager had retired from the service following a period of long term sickness. A new manager had been appointed and had been in post for six weeks at the time of our inspection. The new manager had not yet applied to the Care Quality Commission to become the 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. We received positive feedback from staff about the new manager. One staff member described the new manger as, "A very nice lady, approachable."

People said they were happy with their care. One person commented, "They [staff] are always helpful." People were treated with respect by staff who knew their needs and preferences well. One person said, "[Staff member] helps, [staff member] is a nice lady. She gives me a nice bath, helps me to choose my clothes." People were supported to be as independent as possible. They accessed the local community, went on holidays and maintained contact with family members and friends.

People told us they felt safe and reassured living at the service. One person said, "I can talk to [three staff member's names]." Another person said, "I could phone (staff) but I don't like using the phone so I go and find them."

Staff showed a good understanding of safeguarding adults and whistle blowing, including how to report concerns. One staff member said, "I have seen nothing at all [of concern]. The manager would deal with it straight away and investigate." Safeguarding concerns had been reported correctly to the local authority safeguarding team and investigated.

The quality of some risk assessments was inconsistent and some lacked sufficient detail about how to manage identified risks. All risk assessments we viewed had been reviewed regularly to keep them up to date.

The registered provider had systems in place to check the premises and equipment were safe for people to use. This included portable appliance testing (PAT) checks, a fire risk assessment, a legionella risk assessment and an up to date electrical safety certificate. The registered provider also carried out weekly

and monthly health and safety checks, including fire safety checks. Personal emergency evacuation plans (PEEPs) had not yet been written for people using the service.

Medicines were managed safely. Medicine administration records (MARs) had been completed accurately to confirm which medicines had been administered. Errors in records had been corrected with an explanation recorded as to what action had been taken. People had detailed and up to date medicines support plans.

There were enough appropriately recruited staff to meet people's needs in a timely manner. One person told us, "There are enough staff to look after me." Staff also confirmed there were enough staff.

Accidents and incidents were recorded with details of any action taken to deal with the issue.

Most staff training was up to date. A plan had been developed to ensure any overdue training was completed. Although all staff had met with the new manager for a one to one supervision recently, they had not had regular supervision prior to this. Appraisals for 2015 were not up to date but there was still time to have these completed by the end of March 2016 to meet the registered provider's expectations.

Staff understood their role in supporting people with decision making, including when the Mental Capacity Act (MCA) applied to a person. Advocates were used regularly to support people with making specific decisions. We did not see within people's care records evidence of recorded MCA assessments and best interest decisions having been completed. We have made a recommendation about this.

People had access to a range of health professionals when required, including dentists, GPs, community nurses, podiatrists and specialist nurses. One person said, "The doctor comes to see me in the flat."

People were supported to meet their nutritional needs, including where people had special dietary needs. One person said, "Staff come in to help me with dinner." Another person said, "I go shopping for food at [supermarket name]. I have support to do shopping."

People had their needs assessed which included staff gathering information about people's care needs and preferences. Personalised, up to date care plans were in place to guide staff as to how people wanted their care provided.

A range of activities were available for people to take part in. One person said, "I go to the disco on a Tuesday. I sing at the disco. I go to the club. I do different things, making a snowman for the Christmas tree." One staff member said, "Every day is different. Staff stay to support residents at the Excel club [a local day centre]. They do crafts such as sewing and games."

People knew how to raise concerns if they were unhappy, although people we spoke with said they did not have any concerns about their care. One person said, "I would talk to [staff member] if there was something I was concerned about. I am very happy here." Another person commented, "If I have a problem I can talk to [staff member] it would be sorted." There had been no complaints received since April 2014.

People could give their views about the service through attending regular meetings. One person said, "I attend meetings to talk about what we want to do. I went to one two or three weeks ago." Another person said, "I attend meetings to decide on activities." People were also sent questionnaires to fill in with their views. Feedback from the most recent consultation was positive about people receiving the right support.

There was good communication within the service. The new manager had been pro-active in sending out

memos to staff about changes to procedures. Staff completed a communication book to share important information. Staff members had the opportunity to attend staff meetings. One staff member commented, "There are regular staff meetings and an open door policy."

The registered provider had internal and external checks in place to check on the quality of the care provided. These included weekly and monthly checks of fire safety, people's finances and the quality of care plans and risk assessments. A specific check of medicines was also carried out regularly. Some of these checks had not been carried out in October or November 2015. The registered provider's commissioning team also checked on the quality of people's care. We saw actions identified during the most recent review in October 2015 had been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Some risk assessments lacked sufficient detail about how to manage identified risks. Personal emergency evacuation plans (PEEPs) had not yet been written for people using the service.

People told us they felt safe living at the service. There were enough appropriately recruited staff to meet people's needs. Medicines were managed safely.

Staff showed a good understanding of safeguarding adults and whistle blowing, including how to report concerns. Safeguarding concerns had been reported and investigated appropriately.

The registered provider had systems in place to check the premises and equipment were safe for people to use. The gas safety certificate for the service was not available to view during our inspection. Accidents and incidents were recorded in appropriately.

Is the service effective?

Requires Improvement

The service was not always effective. We did not see evidence of completed Mental Capacity Act (MCA) assessments and best interest decisions.

Staff understood their role in supporting people with decision making, including their role under the MCA. Independent advocates regularly supported people.

A plan had been developed to ensure any overdue training was completed. All staff had met with the new manager for a one to one supervision. Appraisals for 2015 were to be completed by the end of March 2016.

People had access to health professionals when required, including dentists, GPs, community nurses, podiatrists and specialist nurses.

People were supported to meet their nutritional needs, including any special dietary needs they had.

Is the service caring?

Good

The service was caring. People were happy with their care. They were treated with respect by staff who knew their needs well.

People were supported to be as independent as possible and accessed the local community with or without staff support depending on their needs.

Independent advocates supported some people with decision making.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and personalised, and up to date care plans were in place.

A range of activities were available for people to take part in.

People knew how to raise concerns if they were unhappy. People told us they did not have any concerns about their care. There had been no complaints received since April 2014.

People could give their views about the service through attending regular meetings or filling in questionnaires. Feedback from the most recent consultation was positive.

Is the service well-led?

Requires Improvement

The service was not always well led. The service did not have a registered manager. A new manager had been appointed but had not yet registered with the Care Quality Commission.

There was good communication within the service, through regular memos, completing a communication book and staff members attending staff meetings.

The registered provider had internal and external checks in place to check on the quality of the care provided at the service, including checks carried out by the registered provider's commissioning team. Actions identified during a recent commissioning team review had been completed.

Danesfield Supported Living Service

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 16, 23 and 25 November 2016 and was unannounced. Two inspectors and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with the local authority commissioners for the service.

We spoke with seven people who used the service and one family member. We also spoke with the manager, one senior support worker and two support workers. We looked at the care records for three people who used the service, medicines records for 13 people and recruitment records for five staff.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. They said if they were worried about things they could speak with staff members. One person said, "I can talk to [three staff member's names]." Another person said, "I could phone (staff) but I don't like using the phone so I go and find them." Staff confirmed they also felt people were safe. One staff member commented, "There is always a member of staff knocking about."

Staff showed a good understanding of safeguarding adults and knew how to report concerns. They were able to describe potential warning signs they would look out for, such as changes in a person's usual behaviour. Staff said if they were concerned about a person they would report it straight away. We viewed the registered provider's safeguarding log which confirmed concerns had been reported to the local authority safeguarding team and investigated in line with the agreed procedure.

Staff were also aware of the registered provider's whistle blowing procedure. They said they felt concerns would be dealt with appropriately. One staff member said, "I have seen nothing at all [of concern]. The manager would deal with it straightaway and investigate."

Although we found staff regularly assessed potential risks when they were identified, the quality of some risk assessments was inconsistent. Some risk assessments we viewed lacked sufficient detail about how to manage the potential risk. For example, we saw from viewing care records that one person's safety due to mental health had been assessed as 'high risk.' The assessment contained only brief information about the risk. It did not identify the specific controls required to reduce this risk, other than a reference to a support plan. Another risk assessment we viewed for a lower scored risk contained detailed information about the control measures in place. This meant there was a risk staff did not always have access to the information they needed to help keep people safe.

In addition to people's individual risk assessments there were a range of generic risk assessments in place. These related to the premises and the environment. For example, slips, trips and falls and fire evacuation. All risk assessments we viewed had been reviewed on a regular basis to keep them up to date and relevant to the service.

The registered provider took action to keep the premises and equipment safe for people to use. Records showed the service had up to date portable appliance testing (PAT) checks, a fire risk assessment and legionella risk assessment. The registered provider had an electrical safety certificate for the premises and certificates to confirm the gas boilers had been serviced annually. We viewed maintenance records, such as for fire doors. These were up to date and included details of any issues identified. For example, to deal with a fire door on one flat that would not close. The registered provider did not always complete a record of the action taken to resolve these issues.

The registered provider carried out regular health and safety checks. There was a fire check list in place which included details of flat numbers and people's individual mobility needs. Fire alarm testing was carried out. The frequency of the fire alarm testing was inconsistent. Sometimes checks were monthly and at other

times bi-monthly. Fire drills were carried out on a regular basis within the service. Fire drill records showed details of the people and staff members included in the drill, their arrival time at the allocated muster point and the reasons for any people who were unaccounted for. For instance, if a person refused to leave their flat. Other checks included maintenance checks of the lift and equipment used for moving and assisting people.

The registered provider had a specific plan in place detailing the arrangements to deal with emergency situations including a fire. The plan provided details of information the fire service needed, such as the layout of the building and the support arrangements in the service. The registered provider had not yet developed personal emergency evacuation plans (PEEPs) for people using the service. We saw that developing PEEPs had been discussed with staff at a recent team meeting. However, at the time of our inspection these were not in place. A specific night-time emergency procedure had also been developed.

Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for three people. All records were completed accurately, with staff signatures to confirm medicines had been administered at the prescribed dosage and frequency. Where errors in records had been corrected on MARs, staff recorded this on the reverse side of the MAR. The record included an explanation of the error and the correction made. For example, we saw one staff member had signed by mistake for a particular medicine. The signature had subsequently been crossed out as a mistake and a record made of this correction to the record. This meant the risk of medicine errors was reduced.

People had detailed and up to date medicines support plans which described the specific support each person required with taking their medicines. They included a list of each medicine taken and what they were taken for. The support plan also provided brief guidance for staff about any 'when required' medicines the person had been prescribed. These support plans helped staff to understand how to administer people's medicines safely.

A stock check of medicines was carried out four times each day. We viewed records of these checks to confirm they were carried out consistently. The checks included a record of the amount of medicines left in stock when a dose had been administered. These checks corresponded with the MARs we looked at to confirm medicines were administered correctly.

Records in staff files demonstrated staff were recruited with the right skills, experience and competence. Recruitment checks had been completed before new staff started working with vulnerable people. This included checks on their identity, occupational health, reference checks and a disclosure and barring service check (DBS). DBS checks are used as a means to assess someone's suitability to work with vulnerable people.

There were enough staff to meet people's needs. One person told us, "There are enough staff to look after me." Staff also confirmed there were enough staff. One staff member said, "When people are going out there are enough [staff] on." We saw from viewing staff rotas staffing levels were consistent with additional staff deployed to cover specific events such as outings. The manager told us staffing levels were being reviewed as part of a restructuring of all of the registered provider's services.

Records of accidents and incidents were recorded in appropriate detail. Records included details of those involved, what had happened and details of action taken following an incident or accident. Incident and accident records corresponded with the incident and accident log.

Requires Improvement

Is the service effective?

Our findings

Training records showed staff training was up to date in most cases. Where training was overdue, the registered provider had developed a training plan to ensure staff completed this. One staff member told us they had completed training in, "First aid, moving and handling, medication, clean food, safeguarding and Mental Capacity Act."

Prior to the new manager starting, staff had not received regular one to one supervisions and appraisals. Supervisions and appraisals are important to ensure staff have structured opportunities to discuss their training and development needs with their manager. Since the new manager commenced their employment all staff had received a one to one supervision session. These sessions had been used to discuss changes to processes within the service, such as recording service users' finances, health and safety and medicines. The manager told us appraisals for 2015 were not up to date, but the registered provider's expectation was appraisals should be completed by March 2016. Staff told us they felt supported working at the service. One staff member commented, "Very supported, not just by the manager but the staff as well. They are always willing to help."

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 had a good understanding of their role in supporting people with decision making. They could describe to us when the MCA applied to a person and the support people needed to make decisions. Records confirmed MCA training was up to date. We saw from viewing care records that advocates were used regularly to support people with making specific decisions. However, we did not see evidence within people's care records of a documented MCA assessment and best interest decision having been done. We have made a recommendation about this.

People had access to external health professionals when required. One person said, "The doctor comes to see me in the flat." Another person told us, "I tell staff if I do not feel well. I go to reception to talk to staff." Records confirmed people had regular input into their care from a range of health professionals including dentists, GPs, community nurses, podiatrists and specialist nurses.

People were supported to meet their nutritional needs. One person said, "Staff come in to help me with dinner." Another person said, "I go shopping for food at [supermarket name]. I have support to do shopping." The manager told us people had their meals in their own flats. Staff supported people to prepare meals as and when required, in line with individual care plans. Staff supported people, with their written consent, to meet their specific nutrition and healthy eating needs and preferences. For example, when

people had specific medical conditions, such as diabetes or when they wanted to lose weight. However, staff told us people were usually able to choose what food they bought and had an individual shopping list.

We recommend the service considers the code of practice and current guidance on documenting mental capacity assessments and best interest decisions and takes action to update their practice accordingly.

Good

Is the service caring?

Our findings

All of the people we spoke with said they were happy with the care they received at the service. One person commented, "It's nice here and comfortable." They went on to say, "They [staff] are always helpful." Another person said, "I like seeing the staff."

We observed staff members treated people with respect. We saw staff always knocked on doors before entering people's flats. In the lounge areas staff acknowledged people by their name when they passed through. Staff we spoke with understood the importance of treating people with dignity and respect. They gave us examples of how they delivered care in a dignified and respectful manner. For instance, closing people's doors and keeping them covered as much as possible when supporting people with personal care.

Staff supported people to meet their individual preferences. One person said, "[Staff member] helps, [staff member] is a nice lady. She gives me a nice bath, helps me to choose my clothes." Another person told us, "One of the staff took me on a train to Newcastle. I like to go on the train." Staff members said they had access to information in people's care records about what people liked and disliked. People's individual flats were personalised to their particular preferences and interests. We observed items of personal interest in people's living rooms such as cuddly toys and model cars. People had chosen their own bedding and curtains. We saw photos in the lounge area of people involved in various activities.

Staff supported people to help them maintain their emotional wellbeing. People's health needs had been assessed and strategies identified to support people's wellbeing. We viewed one person's daily notes and saw there were records of daily chats between the person and staff to discuss a range of issues that made them feel anxious.

People were supported to be as independent as possible. One person said staff helped them to make their tea. Some people accessed the local community independently. One person said, "On Saturday I go to Shields to the pub and have a couple of pints and play pool." Another person had gone on holiday with a friend. Care records we viewed showed some people were involved in volunteering opportunities, such as volunteering in a shop. People enjoyed the company of other people in the lounge area and when they attended activities in the community.

People were supported to maintain contact with friends and family members outside of the service. One person said, "Family come and see me." One family member told us, "I visit every week on the same day. If there are changes staff will talk to us. If there were problems I would talk to the manager."

Independent advocates were regularly involved to support people when making decisions about their care. For example, an advocate had been involved to help one person make a decision about a new bedroom carpet. Another example of a decision made with input from an advocate included gaining a person's consent to dental treatment.

Good

Is the service responsive?

Our findings

People had their needs assessed shortly after admission to the service. The assessment was used to gather personal information about people to help staff better understand their needs. This included any cultural or religious beliefs people had, their next of kin, a medical history and a brief life history. The assessment also included sensory needs, finances, daily living skills, nutrition, medicines and the person's interests or aspirations. For example, one person's aspiration was to lose weight. The assessment also included details of people's likes and dislikes. For instance, one person particularly disliked spicy food. Other people had identified other food likes and dislikes.

People had personalised care plans in place to guide staff as to how they wanted their care provided. Care plans included details about people's specific preferences and wishes. For example, one person's personal hygiene care plan stated the specific times they wanted to have their daily shower so that they could enjoy their favourite television programmes afterwards. The care plan also stated what support the person needed from staff and the toiletries staff should use. Care plans had been reviewed every three months to help keep them up to date. Another person's eating and drinking care plan provided details of a specific diet they needed due to a particular medical condition. This included details of the person's preferences but also foods they should avoid to remain safe.

There was a range of activities for people to take part in. One person said, "I go to the disco on a Tuesday. I sing at the disco. I go to the club. I do different things, making a snowman for the Christmas tree." One staff member said, "Every day is different. Staff stay to support residents at the Excel club [a local day centre]. They do crafts such as sewing and games."

Staff told us about one person who displayed behaviours that challenged and refused medicines. They said they had referred the person to external health professionals. Staff said the person was now happy and took care of themselves and regularly took their medicines.

People knew how to raise concerns if they were unhappy about their care or the service. Nobody we spoke with raised any concerns with us during our inspection. One person told us, "I would talk to [staff member] if there was something I was concerned about. I am very happy here." Another person commented, "If I have a problem I can talk to [staff member] it would be sorted." A third person said, "I could talk to staff if I was unhappy about things." One family member said, "If there were problems I would talk to the manager." We viewed the registered provider's complaints log which contained no recent complaints about the service. The last complaint recorded in the log was dated 24 April 2014. A copy of the registered provider's complaint procedure was made available for people to view.

There were regular meetings with people to decide on future visits and activities. At the last residents' meeting people had discussed the plays and shows they would like to go to at Christmas. One person said, "I attend meetings to talk about what we want to do. I went to one two or three weeks ago." Another person said, "I attend meetings to decide on activities." We viewed the minutes from the previous meetings. These confirmed meetings were usually well attended. Where people had declined to attend, this had been

recorded in the minutes. Previous topics included redecoration and future outings. Residents' meetings were used as an opportunity to reinforce important information with people, such as health and safety issues and the importance of developing personal emergency evacuation plans.

The registered provider consulted with people to gather their views about their care. We viewed the feedback from the most recent consultation. We saw 10 out of 13 people had returned their questionnaire, with 89% stating they felt they got the right support.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager due to the previous registered manager retiring from the service following a period of long term absence. Due to the absence of a registered manager, some areas were not up to date such as supervisions, appraisals and training. A new manager had appointed and was making progress with bringing these back on track. They had been in post for six weeks at the time of our inspection. The new manager had not yet applied to the Care Quality Commission to become the registered manager. One staff member described the new manger as, "A very nice lady, approachable."

There was good communication within the service. The new manager had been pro-active in sending out memos to staff to change various procedures for the benefit of people using the service. For example, this included simplifying the process for recording people's finances and the recording of medicines taken away from service.

Staff used a communication book during staff handovers. This was used to record things that happened on a daily basis and to direct staff to read a particular person's care records. This helped staff keep up to date with people's changing needs or provided an update on a specific event. For example, we noted in the communication book that one person was not feeling well and was awaiting contact from their GP. Staff said they read the communication book when they came on shift and notes were left to inform them of anything they needed to know about.

Staff had the opportunity to give their views through attending staff meetings. One staff member commented, "There are regular staff meetings and an open door policy." We viewed the minutes from the last meeting held in August 2015. We saw areas discussed included medicines, training and updates on individual people's health and wellbeing. Meetings were also used to discuss care practice. For example, safeguarding adults and the MCA had previously been discussed to help raise staff awareness and increase their knowledge. This included staff working through detailed case studies.

The registered provider had systems in place to check on the quality of the care people received. A weekly care worker's check was carried out consistently each week. Checks carried out included fire safety checks, people finances and whether care plans and risk assessment had been updated. Specific checks of medicines had also been completed regularly including a check of medicines in stock, whether MARs had been completed correctly, medicines storage and disposal records. We found these checks had been successful in identifying gaps and ensuring these were investigated and resolved. Senior care workers carried out a monthly check which included a review of people's support plans. Records confirmed these checks had not been done in October or November 2015.

The registered provider's commissioning team completed additional quality assurance reviews. We viewed the findings from the most recent review, dated October 2015. The review considered a range of topics, including personalised care, staff competence, care planning, risk management and dignity and respect. We saw the commissioning team had made a number of recommendations, some of which had been completed by the time of our inspection. For example, staff had completed MCA training and revised

medicines management procedures had been written and shared with the staff team.