

Lifeways Paragon Limited

Wigan Respite Service

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This announced inspection took place on 07 and 08 March 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care and we needed to be sure they would be available.

Wigan Respite Service is a residential care home providing respite care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This was the first time this service had been inspected since registering under the current provider on 24 January 2017.

Wigan Respite Service is situated in Ince, a suburb of Wigan. Accommodation is provided for up to four adults with learning disabilities, autism and physical disabilities. The property is a single storey building. Facilities include a garden, sensory room, lounge and dining kitchen.

There was a registered manager 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 using the service were safe. Staff we spoke with demonstrated a good understanding of how to recognise risks and protect people from harm or abuse. The service protected people's rights and was compliant with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Staff took care to understand how people made decisions and consented to receive care and support. Positive behavioural support plans were in place and risk assessments reflected good practice in minimising restrictions. The building and facilities were safely maintained.

People using the service had comprehensive assessments and care plans. Care plans reflected people's needs, wishes and preferences and were reviewed and updated regularly. The service consulted with families and other professionals involved to ensure care plans provided enough detail.

Staff had received training which was appropriate to the needs of people using the service. Relatives were able to provide additional information and training for staff to ensure individual needs were met consistently. Regular communication with people's relative's ensured information was up to date.

The service had clear values and the staff team were observed to behave in caring and person centred ways. A broad range of activities were available including karaoke, arts and crafts, cooking and trips to the local community. People's preferences for social activities were known and accommodated. Menus were prepared to reflect people's preferences. There was always a choice of food available. Staff had received training on supporting people to eat and drink, including people needing modified diets.

A clear management structure was in place; in addition to the registered manager, a service manager had been appointed. Relatives and staff we spoke with said the appointment had contributed to an improved quality of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People accessing the service were protected from the risk of harm and abuse and their rights were respected.

Risk assessments were comprehensive and up to date.

Staff had been recruited safely and all necessary checks had been completed.

The building was clean and the facilities were maintained as required.

Is the service effective?

Good ●

The service was effective.

People needs were assessed and care plans developed accordingly which ensured their needs were met effectively.

Staff received training appropriate to their roles and were knowledgeable about the people they supported.

The property had been decorated and furnished to a good standard. Facilities included, a garden, a sensory room and other communal areas.

Is the service caring?

Good ●

The service was caring.

People received support from staff who were kind, caring and responsive.

The service had developed communication strategies to maximise people's involvement and choice.

The service promoted people's rights by accessing advocacy and signposting families in relation to court appointed deputyship.

Is the service responsive?

The service was responsive.

People received person centred care that was responsive to their needs and wishes.

Care plans were reviewed regularly and updates sought from families prior to each stay.

Complaints and concerns were responded to and the service used the information to improve the quality of care.

Good ●

Is the service well-led?

The service was well led.

There was a clear management structure which had improved the overall governance of the service.

Staff and relatives said they felt the service was well led and was continuing to improve.

The service sought the views of people who used the service and their families to promote the quality of the service.

Good ●

Wigan Respite 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.

The inspection took place on 07 and 08 March 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC)

This was the first time this service had been inspected since registering under the current provider on 24 January 2017. Prior to the inspection we reviewed all the information we held about the service including the provider information return (PIR), statutory notifications, safeguarding referrals and complaints. We also liaised with external stakeholders including Healthwatch and the local safeguarding team.

As part of the inspection we spoke with the registered manager, the service manager, and three members of care staff. We spoke to the relatives of three people who used the service. We observed staff providing care and support. We looked in detail at three care plans and reviewed a further two. We viewed other documentation held by the service including: policies and procedures and a range of records the home kept relating to the running of the home.

Is the service safe?

Our findings

We asked three of the relatives of people who used the service if they thought it was safe. One person said, "I feel my child is safe because there are enough staff on now and they are on the ball with how to support them." Another person said, "Things have improved following an incident last year, I keep everything crossed. I am not always confident the door alarm works." We discussed this with the manager who advised the alarm did not sound aloud but activates a pager. The service has recently been refurbished and new assistive technology has increased safety. The service uses a pager system which is linked to all the alarm calls such as, exit doors, call bells and sensor mats. The home keeps a record of pagers allocated to staff and the managers were able to identify how long calls took to be answered and who answered them.

People accessing the service were protected from the risk of harm and abuse. There were clear safeguarding policies and procedures, developed by the provider, stored both online and in a folder which staff were able to access. Relatives were also given information about safeguarding in an information pack. Staff we spoke with were knowledgeable about what might be a safeguarding concern and how to respond to this. One member of staff said, "I have had training, I know that bad practice such as mistreating people would be a safeguarding matter and I would report this to the manager or the local authority." Another member of staff said, "It is clear that it is my duty to report any harm or if the risk is of immediate harm to contact the police."

The service had a positive risk management policy which identified the specific risks a person needed support to manage. Care plans contained risk assessments in relation to all aspects of their health and social care needs including; direct care, moving and handling, communication and social isolation. Risk assessments were reviewed and updated regularly. We could see the service considered the impact of potential restrictions and had sought to minimise this.. Personal emergency evacuation plans (PEEPs) had been completed for each person and provided emergency services personnel and staff with an overview of how people needed to evacuate the building safely. Epilepsy support plans provided clear guidance which ensured staff would be able to recognise the risks associated with an individuals seizures and how to respond. Missing person forms were completed for all people using the service which could be shared with emergency services when necessary.

The service had developed positive behaviour support practices which ensured people's behavioural support needs were identified. Where any support interventions included a restriction on the person these were assessed following best interest principles in the Mental Capacity Act 2005. This showed the service was committed to protecting people's liberty.

The service had maintained the premises safely. Gas and electrical safety certificates were in place and up to date and all hoists and fire equipment had been serviced within required timeframes. Call points, emergency lighting, fire doors and fire extinguishers had been checked regularly to ensure they were in working order. There was also an up to date fire risk assessment and evacuation plan. We saw a record of any concerns or repairs reported to the landlord had been maintained and outstanding concerns had been followed up by the manager. The service maintained an up to date accident and incident file, we reviewed

some of these records and found the information recorded was detailed. Actions taken were recorded.

Medicines were stored and administered safely in line with the service's policy. Medication was stored individually in locked cabinets in bedrooms. Medication administration records (MAR) had been completed and stock reconciled by two staff. There were no gaps in the MAR we looked at. Any previous errors in medication had been investigated fully. Controlled drugs (medicines subject to stricter legal controls because they are liable to misuse) were stored and recorded in the way required by law. We checked the controlled drugs (CDs) and found that stock balances were correct. Some people had been prescribed 'as required' medication, either for pain relief, support with managing feelings or as rescue medication to be used during epileptic seizures. There were clear guidelines for each 'as required' medication, to ensure staff knew when to administer these. Where this medication had been given we saw a corresponding entry in the person's notes to explain why it had been given. Some people needed their medication administering via a feeding tube and there were clear descriptions including photographs in place to guide staff.

There was an infection control policy in place. Personal protection equipment was available including, gloves, aprons and hand cleaning gel. The bathrooms and kitchen were clean and contained essential hand washing facilities. Staff had received training on infection control. Regular checks of the building were completed to ensure standards were maintained.

We looked at how the service ensured there were sufficient numbers of suitable staff on duty to maintain people's safety. We saw staffing levels fluctuated to reflect the different needs of people who used the service at any one time. Decisions were based on dependency levels and risk management. Staff we spoke with said they felt there was enough staff on duty.

We found staff had been recruited safely. Recruitment files included; application forms, interview records, references and proof of identification. Disclosure and Barring (DBS) checks had also been carried out with the DBS number clearly documented. A DBS check is undertaken to determine that staff are of suitable character to work with vulnerable people.

Is the service effective?

Our findings

We looked at how the service assessed people's needs and delivered care and support. Assessments had been completed prior to admission and were reviewed and updated regularly. Prior to each subsequent stay the service had contacted families to check for any changes or new information, which had been recorded on the services' pre stay information sheet. This ensured staff had the most up to date information available.

The service had introduced technology to help improve efficiency and safety. This included a pager system linked to all call points, sensor mats and exit doors which meant staff were able to respond effectively when an alarm had triggered. The building was adapted to meet the needs of the people using the service, which included; accessible bathroom facilities and moving and handling equipment. There were photographs of people's specific hoist slings in their care plans to ensure staff used the correct equipment. There was a large well equipped sensory room which had been developed with input from families. During this inspection we saw this room was enjoyed by the people accessing the service. The service was in discussion with the landlord to improve the building further.

People were supported to eat and drink in line with their preferences and wishes. People's likes, dislikes, allergies and intolerances had been recorded in their care plans. Menus had been developed to reflect these needs and preferences. Records of food and drink consumed were made in the daily recording charts. Information and guidance provided by either a dietician or speech and language therapist (SaLT) had been included in people's care plans. Where a person needed to use a feeding tube clear descriptions and photographs to guide staff were in place which complemented the training they had received.

We looked at the training staff received to see if they had the skills, knowledge and experience to provide effective care. The service had a comprehensive training plan developed by the provider which included training opportunities at all levels. There was an induction programme for new staff which covered a range of modules including; values, safeguarding, person centred care, mental capacity, positive behaviour support and specific long term conditions. Staff had either completed the Care Certificate qualification, or were working towards enhanced qualifications. Ongoing and refresher training was provided for the staff team and included all aspects of care and support. In addition the service had arranged for individually tailored training which had included family members providing guidance to staff on the specific needs of their relative. The service had met with the complex care team and other health professionals who had trained them around the more complex care needs some people had.

Staff we spoke with felt they had received enough training to enable them to meet the needs of the people using the service. One member of staff said, "Training has been good, we get information about specific needs from the complex care team." Another member of staff said, "Training has been very effective, this is the most rewarding service I have worked in."

The service provided regular supervision and appraisal to staff. Staff were aware of the purpose of supervision and reported finding it useful for their understanding and development. Supervisions were seen

to be planned in line with the services policy and there was a monitoring system in place to ensure these were up to date. Additional supervision was available when required.

We looked at how people were supported to access health care. We found people's day to day health care and wellbeing needs had been met as detailed in their care plans. There were copies of health action plans (HAPS) in people's files. Emergency information was recorded in a document developed to provide information specifically for people with learning disabilities going to hospital which promoted effective communication and minimised potential distress. Advice and guidance provided by health professionals was evident in the care plans and we saw these were reviewed and updated regularly. This meant the service was supporting people to maintain their health needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making a particular decision 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 interest and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DOLS). We checked whether the service was working within the principles of the MCA. We found that they were.

Mental capacity assessments in care plans addressed all the decisions about receiving care and support a person may need to consent to. This included receiving personal care, taking medication, using sensor mats and door alarms. We saw decisions made on behalf of individuals, who did not have capacity, were made in line with best interest principles. Applications for DoLS authorisations in relation to restrictive practices had been made to the local authority. The manager kept track of the referrals and followed them up when required. We spoke with staff to check whether they understood the importance of mental capacity and consent. We found the staff were knowledgeable and skilled in relation to this and described the individual approaches they used. One member of staff said, "Anything we do must be in the persons' best interests, they have the right to choose and I respect that."

Is the service caring?

Our findings

We looked at how caring the service was. We observed interactions between the people using the service and staff. Staff were caring in their interactions and focussed on engaging with people encouraging communication. We saw when people needed support staff provided this respectfully and took steps to maintain the person's privacy and dignity. We asked staff how they ensured they maintained dignity and respect. One member of staff said, "I try to be discreet if I think someone needs personal care. I talk to them when offering support to reassure them." Another member of staff said, "I encourage people and try to persuade them to accept support but if they decline I respect that and record it." We spoke to the relatives of people who used the service. We asked them if they thought the staff were caring. One person said, "The staff are caring and kind, they have a nice attitude. I have been impressed by their willingness to learn." Another person said, "I feel the staff are kind and caring."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. People were supported to express their views and sought to involve them in decisions. This had been achieved by the development of effective communication strategies based on the person's needs and abilities. People's communication plans contained detailed information about how best to interact and described people's non verbal gestures. It was evident the service had consulted broadly with families and other services to maximise communication. People were supported to communicate using recognised methods including Makaton signing, individual gestures, communication aids and pictorial guides. We spoke with staff about supporting people to communicate, one member of staff said, "Most people who use the service are not verbal, I follow the support plan, use gestures and build up knowledge over time."

We observed an arts and craft session in the kitchen between one member of staff and one person accessing the service. The staff interacted and communicated with the person throughout, responding to what the person was doing and suggesting in a positive way. The person remained animated and engaged with the activity.

Information about advocacy services was displayed in the office. The service had provided a leaflet about advocacy and court appointed deputies to families, to promote the use of advocacy services and protect people's rights. Staff were aware of the role of advocacy and knew where people's needs and support in relation to advocacy were recorded. This showed the service cared about protecting people's rights. We looked at how the service promoted independence. We saw staff actively involved people in tasks and encouraged them to do things for themselves.

Coffee mornings for families were arranged every month to encourage people to visit and share their experience. Visitors were welcomed at any time. The service contacted family members and updated them on the wellbeing of their relative during their respite stay to provide reassurance. This showed the service cared about the families experience. The provider has a rewards scheme in place for staff known as 'My Lifeways' which provided access to resources and discounts with some retailers. Staff said they felt the

organisation cared about them and they felt valued.

Is the service responsive?

Our findings

We looked at how the service provided personalised care that was responsive to people's needs. We saw that people's needs were individually assessed and plans developed to meet these needs. Assessments were holistic and addressed the person's health and social care needs, preferences, aspirations and cultural identity. People's strengths, qualities and achievements were recorded. We saw people had been involved in the care planning process and supported to express their views. Where the person was not able to provide full details of what was important to them, there was evidence family and relevant professionals had been involved. Staff had received training in person centred care. We found entries in daily records were positive and had been completed using person centred language. Communication plans provided information and strategies to support people to communicate. Staff were observed to follow these when they communicated with people. There were easy read versions of information available including policies, care plans and review documents.

We saw reviews of care plans had been completed at regular intervals. Changes to needs and preferences had been updated and discussed with staff. Staff told us they were notified of changes by the management team and had to read the new sections and sign to confirm they had read and understood them. This showed the service ensured changes were communicated to ensure care provided was up to date.

People were supported to engage in a range of activities. The activities people valued were recorded in their care plans, these included, details about films and music people liked and subjects that interested them. We saw staff used this information when they supported people with activities. People were supported to access local community resources. The service displayed photographs taken during trips, outings and activities to document what people had been doing.

We looked at how the service responded to concerns and complaints and whether this had led to improvements in the quality of care. The service had a complaints policy and procedures to address any concerns raised. The service had also consulted with commissioners who had said they were content with the way a complaint had been managed. This showed the service were involving stakeholders in the complaints process.

The service had actively sought people's views and opinions to continually develop and improve the quality of care and the environment. Information about improvements had been fed back to relatives in a 'You said we did' feedback form.

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The registered manager and service manager were approachable, responsive and accessible throughout the inspection. There was a clear management structure in place. A service manager had been placed in the home full time to improve support and governance. Staff we spoke with felt they were supported by the management team and were clear about what was expected of them. One member of staff said, "I feel it is well managed now with this new manager on site. They are approachable and their door is always open." Another member of staff said, "There are clear expectations, I know what my duties are and I can speak to the manager anytime I need to." We asked relatives for their views on the management of the service, one person said, "I feel confident they are well managed, the home looks better, the manager ensures people know what is expected of them." Another relative said, "They listen, they have taken my suggestions positively and with good manners." Values and culture were an important part of the service; the staff we spoke with were able to demonstrate their understanding of this.

Regular auditing and monitoring had been carried out by the management team and by the provider's quality team. The service manager filled in a workbook each month which included, safeguarding, accidents, incidents, CQC notifications, recruitment, health and safety and complaints. The registered manager reviewed the workbook and recommended any actions. Records showed that actions had been followed up in a timely manner. The quality team completed internal audits with varying frequency based on the outcome of the previous audit. This meant the service received the right level of support to ensure quality was maintained. We looked in more detail at the audits completed in the service, which included monitoring of care plans, daily records, medication and infection control, including cleaning. We found these had been completed regularly and any issues addressed. The service manager also completed spot checks and competency assessments of the staff to monitor performance. Team meetings were held monthly. We looked at the minutes from the most recent meeting which were detailed and included positive feedback for the team. Staff signed the minutes to confirm they had read them.

The home had policies and procedures in place which covered all aspects of the service. These were developed and updated by the provider. The service worked closely with partner organisations including commissioners. We saw discussions had taken place in relation to staffing levels, budgets and compatibility of different groups of people using the service at any one time to ensure the quality of service.

The service engaged with people who used the service and their families in a variety of ways. Annual customer satisfaction surveys had been used but were not felt entirely appropriate for the respite service. The registered manager advised they hoped to redesign these to reflect the experience for the respite service. Relatives said they were contacted regularly by staff to keep them up to date and seek their views. Monthly coffee mornings were held for families to give them the opportunity to meet and discuss any issues

they wished. We spoke with some relatives to see how they felt the service engaged with them. One person said, "They encourage feedback." Another person said, "The service manager is open and seems to listen to what you are saying, she will update me, my trust is improving."