Independent Living Solutions Limited

Independent Living Solutions Limited

Inspection report

2 Wilton Business Centre
Wilton
Salisbury
Wiltshire
SP2 0AH

Tel: 01722742442
Website: www.indliv.co.uk

Date of inspection visit:
19 April 2018
27 April 2018

Date of publication:
26 June 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 19 and 27 April 2018 and was announced.

Independent Living Solutions provides specialist care and support packages to people living in their own homes. They work with people who have an identified need such as spinal cord injury, brain injury or cerebral palsy. They provide a case management and rehabilitation service to children and adults.

Not everyone using Independent Living Solutions receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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 and their relatives told us the staff were caring, there were good support teams in place and people were treated with respect and dignity.

People were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received appropriate training and were able to recognise any safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

Where risks to people had been identified, risk assessments were in place and guidance for staff on how to minimise those risks.

Consent to assist people was gained prior to any action or activity undertaken. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and were able to apply this in their work with people.

Deprivation of Liberty Safeguards (DoLS) applications (court orders) had been made to the Supervisory Body appropriately, however not all documents were in place regarding health and welfare decisions for people who lacked capacity to make these decisions. We have made a recommendation about best practice regarding the Mental Capacity Act.

Care plans detailed people's preferences, choices and independent abilities. Care plans were person centred and people and their relatives had been actively involved in developing their support plans.

Staff spoke positively about the support they received from the management team (team leaders, case managers and the registered manager). All staff received regular one to one supervision with their case manager.

Relatives, professionals and staff told us the service was responsive and well managed. The service sought people's, their relatives and staff views and opinions and acted upon them.

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.

Staff understood how to identify abuse and the procedure for reporting any safeguarding concerns.

People's medicines were managed and administered safely.

Detailed risk assessments were in place where risks had been identified and clear guidance for staff on how to minimise those risks.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was effective.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles. However, not all capacity assessments were in place. We have made a recommendation about this.

People's needs were assessed and care was planned to ensure it met their needs.

Staff were skilled and well trained. Additional specific training was sourced in response to people's specific needs.

Staff received regular supervision and had a mentor.

Is the service caring?

Good

The service was caring.

People and their relatives told us the staff were kind and caring and provided respectful and dignified care.

The staff we spoke with were knowledgeable about people's individual needs and how best to meet them.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People, their relatives and staff knew how to raise concerns and were confident action would be taken.

People were treated as individuals and their diverse needs respected.

Is the service well-led?

Good

The service was well-led.

The service had received good feedback from people, relatives, staff and professionals.

There were systems in place to monitor the quality of the service.

Independent Living Solutions Limited

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 19 and 27 April 2018. We gave the registered manager 24 hours' notice of the inspection. The provider was given notice because the service provides a domiciliary service and we wanted to make sure the manager would be available to support our inspection or someone who could act on their behalf.

The inspection was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed all of the information we held about the service including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send us.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We visited one person at home, and spoke with six people and their relatives. We spoke with three health professionals, the registered manager, and the general manager. We also spoke with three staff members.

We looked at electronic and paper records relating to people's care. The records held in people's homes are called their 'working file'. We also looked at records relating to the overall management of the service and

three staff personnel files.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe. Comments included, a thumbs up sign from a person we visited and a sign meaning 'yes'. Relatives told us they felt safe knowing that people that matter to them were in safe hands and they had, "no cause of concern from Independent Living Solutions and the support staff."

Staff told us how they would recognise abuse and what they would do about it. One member of staff told us, "it's about keeping [the person] safe in here and out in the community. There is a protocol in the working file. I would talk to [the case manager] and ring the safeguarding unit at [the local authority]." The staff we spoke with were also knowledgeable about their responsibility to whistle blow. Whistle blowing is the term used when a worker passes on information concerning wrongdoing. The wrongdoing will typically (although not necessarily) be something they have witnessed at work. Procedures ensure that staff are protected from reprisals. There were no incidents of whistle blowing at the time of our inspection.

Safeguarding policies and protocols were in place in the office and in people's working files. An Independent Living Solutions safeguarding flowchart was in place which stated 'our role as a non-statutory agency is to ensure that any issues and concerns are communicated to the appropriate authority without delay.' Guidance on the types and indicators of abuse were observed as well as the contact numbers to report any concerns. A staff member told us, "It is always covered as part of the induction, there is a safe guarding protocol in the working file, and it is covered in the handbook."

People were protected from risks. Individual risk assessments and associated guidance were present giving clear instructions to staff on how to minimise risk. For example, one person had a risk assessment around eating and drinking. The guidance had been developed with the speech and language therapist and stated, 'food should be texture C pureed diet. Please refer to the dysphagia diet texture C information sheets in the working file for food types and further information.' This person's eating and drinking management plan also included information to avoid certain foods to which the person had an allergy and guidance on safe positioning when eating and drinking.

There were safe and robust recruitment processes in place. The records and recruitment files we saw included all of the required safety checks relating to past employment, references, identity checks and DBS. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

Staff were recruited using an on-line application system. Case managers developed job descriptions specific to the person's requirements, this included particular qualifications, interests and work experiences. A short-list of candidates was then sent to the person requiring support and their family for them to choose who to interview.

People were supported with the administration, storage and disposal of medicines in a safe manner. The service had a medicines policy and protocol in place. For PEG administered medicines, the staff member

had specialist training from a qualified nurse practitioner. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate (for example, because of dysphagia or sedation).
One person's working file contained guidance from the speech and language therapist on how to crush medicines to a desired consistency to enable to the person to swallow them safely, 'not powder, but small lumps to encourage [person] to swallow.'

We observed MAR charts (medicine administration records) in a person's home which were completed accurately with the prescriber's information and guidance. PRN (medicines to use as needed) protocols were also in the working file. Homely remedies were recorded in the daily care log and on the MAR chart. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used for the short-term management of minor, self-limiting conditions, e.g. headache, cold symptoms, and mild occasional pain. However, there were no body maps or protocols in place for the application of topical medicines, such as creams and lotions. This is an area the service has identified as a developmental requirement.

People were protected from the risks of infection and there were infection protocols in place. People's working files contained guidance for staff on the principles of effective hand washing. The staff we spoke with told us how they use personal protective equipment (PPE) such as gloves and how to dispose of items appropriately.

The service was able to learn from mistakes and take the appropriate action. For example, the registered manager told us that the services previous safeguarding process was, "not responsive enough." The registered manager reviewed and restructured the reporting process. This meant any concerns were now discussed directly with the operations team and referred to the local authority safeguarding team. This was introduced as part of their service improvement plan.

Requires Improvement

Is the service effective?

Our findings

The service ensured that all staff were aware of the Mental Capacity Act (2005) by use of on-line training resources by The Social Care Institute for Excellence. This is followed by the case managers confirming support workers knowledge and understanding, by appropriately answering a series of questions prior to being 'signed off.' Guidance for staff on how The Deprivation of Liberty Safeguards applied to people in their own home was also available. This detailed the possible nature of a deprivation of liberty, and how and when to apply for a legal authorisation.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. For people receiving care in their own home this is an order from The Court of Protection.

In the care records we observed, there were no mental capacity assessments, best interest's decisions or details of Lasting Powers of Attorney for health and welfare decisions. However, the service had records of Court of Protection orders for people relating to their finances. Although consent was gained to provide care and mental capacity was assumed (in line with the principles of the mental capacity act), this meant that in some cases, the legal process to consent to receive care and treatment was not followed.

We recommend that the service finds out more about mental capacity assessments, best interest decisions and court orders for health and welfare decisions, based on current best practice.

The service sought people's consent. We observed guidance in working files and care records which instructed staff on gaining permission to assist the person prior to each intervention or activity, 'always gain [person's] permission'. Staff demonstrated their understanding of consent and how to enable people to give consent. For example, one person who was unable to verbalise consent was assisted using pictorial diagrams, the staff member asked if they could take their picture, the person was able to respond by pointing to a picture of a smiley face, which for this person, means 'yes'. Another staff member said, "consent is to give permission, it starts with understanding the client has limited communication and insight."

People's needs were assessed prior to accessing the service to ensure their needs could be met. Some people received rehabilitation and therapy services only and others received a full daily support package. The registered manager told us that people who use the service "are matched with a case manager who had the skill set to support the person." Not all referrals to the service are taken, for example a case manager told us, "there is no pressure to take a case if we feel it is outside of our skill set and experience."

People and their families had been involved in the assessment and care plan process. A holistic 'immediate

needs assessment' was undertaken. This included areas such as, the physical and cognitive impact of the injury sustained as well as the person's leisure, family life and home needs. Care plan reviews were held regularly. Relatives we spoke with said they all had individual case managers and team leaders who reviewed the care plans on a three monthly basis. Relatives told us they could be part of the review process to "make sure everything is right" for their family member.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. We observed staff training records which were regularly updated and reviewed annually. Staff training encompassed the standards from the care certificate as well as training to support specific care needs, for example mental health conditions. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life consisting of the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One relative told us, "[staff member's] training is all up to date, first aid and everything else is in place." Another relative said, "ILS are always passionate and eager to have their care staff fully updated with all necessary training for individual needs." Staff comments included, "I am definitely happy with the training" , "I consider this training we are receiving is the best which could be offered" and "[manager] is really hot on training, it is always booked in. I think the training is really good."

Staff told us and records confirmed they received support through regular one to one supervision. The registered manager told us "there is no case manager in the company without a mentor" and "it's one of our strengths and it's very supportive." Newly recruited staff went through an induction period. The induction ensured staff were trained in areas such as equality and diversity, the mental capacity act, person centred care and understanding their role. Supervision during this period was monthly. Part of the induction process involves the staff member having trial shifts in the person's home whilst being monitored and fully supervised. This process enabled the person being supported, and their family, to identify how they interact and if they can get along with the new staff member. A case manager told us that many of their care teams have staff members who have been employed for several years, retention of staff in some areas is high.

People are supported to eat a balanced diet of their choice and appropriate to their needs. For example, one person who has a visual impairment was supported by staff who check the use by dates of foods in their fridge. They are also supported to shop twice weekly to avoid foods becoming out of date. This person is encouraged to stock their own fridge to enable them to be aware of where items are located. Another person had an eating and drinking management plan to guide staff on which foods the person was able to eat independently and which foods they required assistance with. This person was also reviewed regularly by the learning disability nurse to ensure they are receiving adequate nutrition to maintain their weight.

The service developed teams of health professionals and support workers to ensure people were supported to maintain good health and social care outcomes. A large part of the service is based around multi-disciplinary working as the needs of the people they support are highly complex. The support teams consist of speech and language therapists, occupational therapists, physiotherapists and psychologists to identify a range of needs and develop a holistic care and support plan.

One person's care and support records showed how the service worked alongside staff in a rehabilitation unit to aid the person's transition back home. A staff member told us "it's not just about care, it's the whole package", for example the adaptation and design of the person's home was also part of the assessment. The staff team worked together to ensure that the person's home environment was appropriate in terms of space, equipment and layout.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. One person we asked smiled and used a sign to say 'yes' when we asked the question. Comments from family members included, "they really care and are interested in what makes [person] happy." Also, "it's not just a job for our care staff that look after my son, they actually really care about him."

People's relatives were complimentary about the consistency and the standard of care. One relative said, "the team is so much more stable, [name of person] knows exactly who is coming in and [their] life is so much more settled and calmer." Also, "care staff have never missed to call on them, and they always turn up." Another relative told us, "my son receives 24 hour care, it's a brilliant service provider, he receives first class care."

Staff provided emotional support for people. A working file we observed had specific guidance to help the person to recognise their feelings. It detailed the physical responses which the person may display, for example rocking or frowning. The guidance for staff to help the person was for them to say, "I can see you are rocking [name of person], are you feeling angry?" The guidance then offered solutions which the staff member could apply, including saying to the person, "let's try using some music or your weighted blanket to help." Calming strategies were also used, such as 'use a low, calm steady tone of voice, quieter than normal speech.' These responses and solutions were monitored to recognise themes and if the strategies were working.

The relatives we spoke with said they and their loved ones had been involved in the creation and reviews of their care plans. People had 'a say' in the way the care was provided to them and if they were unhappy with anything the team would look to resolve the issues immediately. A relative told us that their loved one was involved in all of their care decisions. For example, the person decided not to attend a particular activity as he didn't like it and wanted to stop going. The activity was cancelled, "every decision comes from [the person]."

People's dignity and privacy were respected. One person's care records showed that when they requested some time alone, this was respected by the staff member. A staff member described how they would ensure the person's dignity by always talking and discussing what was happening, for example, "Simply moving them from the shower to the sink to clean their mouth would be discussed." A visiting professional told us, "I have only ever seen the support workers I have worked with provide care in a respectful, dignified and motivated way."

People's information was stored securely at the office and in people's homes in a place of their choice. The service has a Share Point computer data storage and communication system in place. Directors, managers and support workers all have different levels of access to the information to protect people's privacy.

The staff group are supported to achieve a high level of job satisfaction. A professional who works closely with the service told us, "the impression I get is that the support workers feel valued and supported and are

devoted to their client and the client's family." A staff member told us, "[the team is] amazingly supportive, I am developing my career and I love it." A case manager said, "It's not all about the big stuff, we enabled a person to go back onto a yacht, we found a pub where they would puree the food, it's about quality of life."

Good

Is the service responsive?

Our findings

The service ensured people had access to information in a format that met their individual needs. In doing this, the service was compliant with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

One person's care and support plan detailed how to communicate effectively with the person. For example, 'It is essential the support workers do all they can to support [person] so [they are] able to express [themselves] either by verbal means, written means or gestures. Offer [person their] communication pad or obtain confirmation of [their] wishes, ask yes and thumbs up never assume.' This person was being supported by speech and language therapists to increase [their] verbal vocabulary as part of their goal setting.

The service was responsive to people's changing needs. Care plans and working files had been updated annually or according to a change in the person's needs and showed when the next review date was due. One person's care plan detailed a review of the use of their wheelchair. The case manager identified that the person required a new piece of equipment to enable the person to continue to use the wheelchair independently.

Another person had a 'long term' and 'short term', goals plan in place. The short term goals were smaller steps made towards achieving the long term goal. For example, the long term goal was, 'to consider alternatives that would meet [their] physical and intellectual requirements and to identify appropriate ways of pursuing these leisure activities as identified by [the person]'. Smaller goals in place were, '[person] enjoys riding on a Thursday afternoon during term time but has expressed that [they] do not wish to ride in the winter' and [person] enjoys membership of [a local] spa'. This meant that the person had achievable small goals, which could be changed as required.

People were supported to maintain their social interests and hobbies. For example, one person who has a visual impairment is enabled to participate in gardening. Relatives told us that the service is proactive in providing support to do interesting things that the person chooses. One relative told us, "[the person] is taken out to the gym three times a week, and also does lots of trips and outings." Another said, "care staff take my [family member] on all sorts of activities like sailing, cycling, mechanic's and woodwork." Also "they take my [family member] out ice skating and farming, and [they] love it."

People's diverse needs were respected. The service had recruited one staff member whose first language was not English to match the person they would be supporting.

Care and support plans detailed the person's preferences, specific guidance for the staff member and outcomes for the person. These were also cross-referenced to other relevant guidance in the care plan. Relatives told us that "[their loved ones] needs were always met, rarely did they have any issues" and "[they] have an individualised care plan centred on [the person's] needs and choices". For example, in one person's

care plan, their morning, lunchtime, afternoon and evening routine and how to assist the person according to their choice at the time, was described in very specific detail. Throughout the care plan, the person's abilities and preferences were integral to the guidance, "[person] will advise best method", "[person] is able to shave himself. He will pass the razor to carer to rinse between strokes" and "[person] will advise which clothes he wants."

Concerns and complaints were managed appropriately. The service has a printed leaflet which they provide to people, their relatives and health professionals. It gives contact details on how to give 'comments, compliments and complaints' via email, telephone or an online feedback form. The service makes contact to acknowledge the receipt of the complaint and who will be dealing with it. The service had not had any formal complaints at the time of our inspection. A relative told us that they have a day time phone contact number and also an out of hours contact number if they needed to raise any issues or concerns. Another relative told us, "if [they] ever had reason to complain [they] can contact the case manager and team leader directly."

The service does not currently have end of life care plans in place for the adult people they support, as the service focusses on rehabilitation and regaining independence. There are no current advanced decisions to refuse treatment orders (ADRT's) made by people using the service. They stated that they 'have undertaken discussions around the end of life when necessary, relieving the family of this burden and enabling them to have more time to deal with their situation in supporting their family member.' A staff member we spoke with confirmed that end of life care discussions had taken place with the person they were supporting. This is an area the service had identified as a developmental requirement.

Good

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 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 spoke with the management team about their vision for the service. The statement of purpose included their aims and objectives and the service it provides in terms of case management. The registered manager told us, "the whole basis of case management is to return [the person] to their pre-injury lifestyle at home." The ethos of the service was described as "enabling, can-do, seeing what we can do to make things happen."

Staff told us they had confidence in the service and felt it was well managed. One staff member told us, "[manager] is always available when needed" and another said, "I just feel that whatever you need they are always there for me to ask anything." The management team we spoke with felt very well supported. The service is managed by a family tree made up of a board of directors, operations and general managers, clinical leads and professional mentors. Each tier of staff member had access to a mentor.

The service had a positive culture that was open and honest. Feedback received from people, relatives and staff was positive. Relatives told us that they were able to put their views across to the case manager and team leaders and felt they were always listened to by ILS. One member of staff said, "[The registered manager] is excellent, kind approachable and very efficient "another staff member said, "they have always been there when asked." Feedback is gathered during team meetings and supervision sessions, but the service does not currently have the process in place to raise concerns anonymously, (such as an anonymous suggestions box or system). This is an area the service had identified as a developmental requirement. However, any staff member was aware that they could go to any member of the management team to raise an issue.

There were systems in place to monitor, record and investigate accidents and incidents. For example, there were forms in each persons home which the support worker completed. These formed part of the quality monitoring process which the registered manager reviewed and any themes or behaviours were identified. If there were notable changes in behaviour, a new behaviour support plan would be created by the case manager, with the person and their family.

The registered manager monitored the quality of the service provided during a monthly audit meeting. The registered manager told us, "we identify themes, ask how to improve and make things better." Information was gathered via regular returns of care logs, supervision records and professional mentor packs. These included details on training requirements for staff, identified changes in risks or needs of people and required updates for care plans and 'working files'. This information was collated and sent to the mentors five days prior to supervision. The information went through a traffic light system recorded on a spread sheet which was constantly updated. If required dates for returns were missed the staff member would get a

yellow reminder (first warning), if a red warning date was passed the staff member would be referred to the operations team for potential disciplinary action.

The quality of the guidance in each management plan was also monitored, a staff member told us, "If I had to use a member of staff from another team would they be able to work with the person using the current guidance?" Another staff member said, "it is a matter of good practice, everyone reads through the management plans to be up to date [with the care needs of the person]." Spot checks were carried out annually to monitor competency.

There was a hierarchical system of mentoring and quality checks from support worker, team leader, to case manager and then registered manager. The registered manager told us, "if something has changed then it doesn't get missed, it will be identified in one part of the process."