Cheshire East Council

Congleton Supported Living Network

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

Overall summary

The inspection took place on 15 and 19 December 2014. The provider was given 48 hours' notice because the location provides a supported living service to people in their own homes and we needed to be sure that someone would be in. The service was last inspected in October 2013 when it was found to be meeting all the regulatory requirements which apply to this type of service.

Congleton Supported Living Network is one of a number of services provided by Care4CE the in-house provider of social care services for Cheshire East Council. The Network provides personal care services to adults with learning disabilities in their own homes. This arrangement is called 'supported living' because people are supported to live, often in groups, in properties which are provided by a social or other landlord.

Summary of findings

The Network accommodates 21 people in the Cheshire East and South areas of the County and all these places were allocated at the time of the inspection.

The service has a 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 found that the Congleton Supported Living Network provided a personalised service to the people who lived in the network. People were able to live as close to an ordinary life as possible and could pursue their own leisure or work interests. The network staff provided people with support which was tailored to people's individual needs.

The staff were well-trained although some "refresher" training would soon be needed and the registered manager was aware that Disclosure and Barring Checks also needed renewal. There were good systems in place to protect people from harm and staff had a good knowledge of people's individual needs

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who lived in the network and their relatives told us they felt safe and no one that we spoke with expressed any concern about this aspect. Medicines and finances were properly looked after and people were protected from risks.

The provider took steps to make sure that the people employed in the network were suitable to do this kind of work.

Is the service effective?

Good

The service was effective. This was because the staff were reliable and did what people expected of them. They understood that it was important that people consented to their care and knew what to do if there was any doubt about this.

The staff were well-trained. Other agencies told us that they found the service to be cooperative when they needed to work together with them.

Is the service caring?

Good

The service was caring and people told us that they liked the staff because of this. Staff took time to make sure that people's privacy and dignity was respected. They helped people to live independently.

Records were kept securely and people could be reassured that information about them was kept confidential. Staff tried to find out what people wanted and tried to help them to achieve these wishes.

Is the service responsive?

Good

The service was responsive. There were good care plans which meant that the staff knew the best way in which they could provide support for each person as an individual. People were involved in planning their own support but the system of annual reviews had fallen into disuse.

There were arrangements for making complaints. The service tried to adapt to people's changing needs.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post who made sure that there were systems to support staff including supervision. There were good arrangements for communication between the different groups of staff who worked in the network.

There were management information systems in place which allowed the registered manager to monitor the standard of service. Areas of risk such as medicines and finances were audited regularly so that errors could be detected and corrective action taken quickly.

Congleton Supported Living Network

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15 and 19 December 2014. The provider was given 48 hours' notice because the location provides a supported living service to people in their own homes and we needed to be sure that someone would be in.

The inspection team was made up of two adult social care inspectors on the first day with one of the inspectors returning on the second day. 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 sent out questionnaires to some people who used the service as well as staff and community professionals.

We undertook this inspection by visiting two people separately in their own homes and talking with them. We spoke with three other people who used the service as well as one relative who came into the office to see us. We also telephoned and spoke with three more relatives of people who used the service. We talked with a total of five care staff as well as two supervisors and the registered manager. We looked at nine care files and eleven staff files. We also looked at a range of performance management and audit information including that relating to staffing, medicines and financial administration.

We also made contact with the local authority which commissions the service from the registered provider as well as having responsibility for safeguarding adults. We spoke with the local NHS Community Health Team.

Good

Is the service safe?

Our findings

All of the people we spoke with together with their relatives said that safety was not a concern for them. One person told us "The staff are nice. They don't shout at you or anything". None of the other people we spoke with or contacted about the service expressed any concerns about the safety of people who were living in the network. Relatives told us "(My relative) is safe and almost as soon as she visits us she is ready to go back (to the network)" and another said "I do feel that (my relative) is safe – (the staff) are all kind".

We talked with staff about how they could be sure that people living in the network were safe. They correctly identified some of the areas of risk that might affect people and how they would identify if something was wrong by using their knowledge of that person. They told us that signs might include otherwise unexplained mood swings or someone behaving in a way that was unusually withdrawn. They told us they were observant in this regard and "listen carefully if people talk about anyone (unusual or unfamiliar)". Staff told us that they would report anything they suspected to be untoward through the management chain. One member of staff recalled an incident some years ago where they had reported concerns and these had been dealt with correctly.

Staff described safeguarding training to us. This had most recently been provided through "blended" learning days during which a number of topics were "refreshed" so that staff would have the most up to date knowledge. This training was provided by the parent organisation of which the network was part and so the registered manager was reliant on them to organise it. We checked the training records and saw that most of the staff had last been trained in 2011 or 2012 and so were likely to require further training in the next twelve months.

We saw that staff made sure that everyday security measures were included in their discussions with people so they could keep themselves safe. For example we saw that in the minutes for one tenants' meeting home security precautions had been discussed. The network had adopted the safeguarding policy of its parent organisation and we saw that a copy of this policy was available. This policy was dated 2010 and was due for review.

A system of care concerns was in place which meant that the network reported any untoward incidents to the local safeguarding team who might then make further investigations. The team told us that they were satisfied that the network reported appropriately. Where appropriate the Care Quality Commission was informed of the outcome. This meant that people were safeguarded.

Some of the people who live in the network require assistance with their finances and medicines. We saw that where people pooled their finances for the hire of a vehicle this was explained in detail to them before they agreed to this. Where staff handled money on behalf of people this was also recorded in detail and a daily reconciliation completed so the money was properly accounted for. We looked at the logs for these reconciliations and saw that most discrepancies were identified as clerical errors. In each instance remedial action was identified including the provision of additional training. This meant that the likelihood of people suffering financial abuse was reduced.

People were able to store their own medicines securely in their own rooms. Where staff assisted them with medicines they were granted access only on a "need to know" basis and security arrangements were routinely varied. This reduced the risk of someone gaining access to the medicines who was not authorised to do so.

Most medicines were dispensed to people using a monitored dosage system. This meant that medicines were prepacked by a pharmacist into the correct doses for each time of day and supplied to the people for whom they were prescribed in a sealed tray. This reduced the risk of too much medicine being taken or medicine being taken at the wrong time. We saw that regular audits by senior staff helped to identify any irregularities and that these were mainly confined to errors in recording on the medicines administration record. Appropriate action such as retraining was then taken. This meant that people received the right medicines at the right time. We saw that the use of "homely remedies" was specifically sanctioned in writing by each person's GP. We saw that there were detailed instructions for the use of "as required" or PRN medicines on one of the care files we looked at. This meant that staff could be sure of when to administer it.

We saw that the provider undertook regular assessments of anything which might pose a risk to each person living in the network. These were chosen according to each person's individual situation. Most commonly they

Good

Is the service safe?

included bathing, medicines, support in the community and finances. We found that these assessments were very detailed so that staff would be clear about what they had to do and that they had all been reviewed recently. This meant that care was provided in a way that would reduce these risks to the person concerned.

We looked at staff files to see if the registered provider took steps to make sure that people working in the network were suitable. We saw that the provider used an application form to obtain an employment history and took up references from previous employers or other appropriate sources. Staff files each had a photograph of the employee as well as proofs of identity. We saw that Criminal Records Bureau checks had been made dated 2010 and 2011 but in one instance dated back to 2004. The registered manager told us that the parent organisation undertook these (now Disclosure and Barring Service) checks and that a programme of updating them was in hand. Registered providers should use risk assessments to determine the frequency with which they update these checks.

During our visit we saw that care was organised on the basis of three staff to each group of two people who used the service. Staff told us that where necessary supervisory staff arranged to work shifts. We were told that there were vacancies on the staff team but that the registered provider sometimes covered these by the use of agency staff. Because the registered provider managed a number of locations staff could be redeployed from other services where they were no longer required. Staff told us that they had found this to be a positive experience.

Good

Is the service effective?

Our findings

People told us that they felt that they received support from consistent care staff who they knew. They told us that their care workers were reliable, stayed with them for the correct length of time, completed the required tasks during the visit, and helped them to be as independent as possible.

We saw that care files each contained detailed assessments of people's needs. Most often these took the form of an assessment by the local authority which placed people in the network in conjunction with the social landlord.

The people who live in the network are a stable population which does not change often. There had been three new admissions in the year before the inspection. We looked at the arrangements which were made prior to a person joining the network as a new tenant. In one instance the person had transferred from another local service and was well-known to the registered manager who had been able to use this knowledge so as to enable a smooth transition. In another instance we saw that expert opinion from a clinician had been provided so that staff would know how to respond to that person's particular and very specific needs.

We asked staff how they made sure that the care they were providing was what the person wished. Staff told us that they used the notes contained in the care plans to guide them about needs and preferences as well as their knowledge of the person. They were clear that they could not force a person to accept care they did not consent to. For most day to day care tasks they relied on implicit consent which is given when a person cooperates or otherwise willingly accepts care. One member of staff illustrated this by telling us "I'd never say you are having this or that to eat tonight – I would always show (the person) the choice to see if they liked it". When we saw staff with people who used the service we saw that they took care to check that they were comfortable with proposed actions including meeting with us.

The Mental Capacity Act 2005 includes arrangements for people who are not able to consent to certain decisions. The Deprivation of Liberty Safeguards do not currently apply in a setting such as the network where people are tenants in their own homes and so any deprivation of liberty may only be undertaken with the authorisation of the Court of Protection. No applications had been made to the Court on behalf of people living in the Network. We saw that the registered manager had been actively reviewing this matter and had taken appropriate advice relating to it.

Where a formal assessment of capacity was required we were told that this would be provided by the local authority. Where capacity is felt to be impaired around a particular decision a best interest meeting of people who know the person can determine the best course of action. The registered manager described a current matter which was being resolved in the network. It was clear from this description that best interest-type considerations were being included.

Most of the people living in the network had a deputy. A deputy is authorised by the Court of Protection to make decisions on a person's behalf either about property and financial affairs or about medical treatment and how a person is looked after. Another person had made a lasting power of attorney arrangement. This meant that the registered provider had taken steps to make sure that arrangements were in place to help people who might not be able to make certain decisions for themselves.

We checked the training records for the staff who worked in the network. We saw that staff had completed induction training which provided them with an introduction to their role. This included visiting some of the houses and a period of observed practice. This meant that their supervisors could assess that they had the necessary skills and knowledge to work alone. We saw that following this staff had completed training in health and safety, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and equality. All staff were trained in medicines administration. Staff had also completed training where appropriate and in respect of certain specific conditions they might encounter such as autism, dementia, multiple sclerosis and epilepsy or for using specialist equipment such as oxygen. One person told us "The staff know what they are doing".

We noted that according to these records some staff had not received certain elements of training (such as health and safety) since 2011 meaning that they might require some update training. The registered manager told us that he was aware of this and the registered provider had arrangements in hand to respond to this.

Good

Is the service effective?

We saw that within each house in the network there was a communications book. Staff entered any information of note into this book which was then brought into the office at the end of each shift for the next worker to collect. This meant that information was passed between different shifts of workers which would promote continuity. We saw that these were reviewed by senior staff on a regular basis.

Staff told us that they sometime had to deal with behaviour which can be experienced as challenging either because it is unexpected or unusual for a person. We saw that staff had been trained in how to respond to this. In some of the care plans we looked at we saw that there were clear arrangements for dealing with these situations and that these were written from the point of view of how these situations could be avoided or detected early on and prevented and what would be most helpful to the person in that situation.

People told us that staff in the network helped people who lived there to plan their menus, undertake shopping and prepare food depending on their needs and preferences. In one instance we saw that a pre-prepared printed list of foodstuffs allowed a person to make their choices whilst another person told us "I cook on my own" and third said "I go shopping on a Wednesday. I buy the things I like to eat".

We visited one house and saw that a menu was displayed on the wall and that the freezer was well-stocked. This meant that people could change their mind about what they wanted to eat if they felt like it. We saw that staff had access to information about special requirements such as low-fat diets and that pureed food was provided to another person on the recommendation of a speech and language therapist.

Some of the people who received support from the provider had difficulty in communicating verbally. On each of the care files we looked at there was a "patient passport" which provided key information which would be of use to another agency such as a hospital or clinic and would help to make sure that the person received the right treatment.

We saw that people had their health care needs met from a wide variety of services including the GP, consultant physicians from the local hospital as well as from the nursing and other professions available in the local specialist community team. They told us that they felt that the network worked "really well" with them and carried out their health care recommendations. We were told that the role of health facilitator had been introduced so that people would have a single point of coordination when they were dealing with the NHS. Local commissioners had also arranged for another provider to give support whilst someone was living in the network and we saw that the registered provider took care to make sure that arrangements about this were clear.

Good

Is the service caring?

Our findings

One person who lived in the network told us "I'm happy I am. If I need anything they (the staff) get it for me. They do their job properly. I'm happy. I'm really happy". People told us that they valued the privacy staff afforded them. One person said "I've got my own bedroom and it's very good" and another told us "I've got a safe in my room". Relatives told us "The staff are wonderful and my relative is very well cared for" and "The carers are excellent – the key workers are super" and "The staff are really caring people who take a pride in their job".

People who lived in the network enjoyed a high level of privacy and dignity because they lived in their own homes. Within each house each person had their own bedroom as well as access to communal areas such as the kitchen and bathrooms.

Staff told us that they maintained people's dignity by making sure if they needed to discuss anything with a person they did so in private in the person's own room. We saw that the registered provider had arranged for sensitive issues to be documented separately to the main running records so as to preserve privacy. We found instances where particular documents had been marked in such a way as to make it clear that they were highly personal and must not be read without the explicit permission of the person concerned. We saw minutes of a meeting with people at which staff had taken care to reassure them that a forthcoming staff induction and observation visit would be conducted in such a way so as not to compromise their privacy.

All the staff we spoke with at each level of the organisation had a good knowledge of the people they were caring for. When they spoke with us it was clear that in many instances they had worked with the same people for some time and had become very familiar with their likes, dislikes and preferences.

During the inspection we saw that the staff of the network acted as lay advocates for the people who lived there if they did not have anyone else suitable to do this. If a person was not able to get something they required such as a housing repair, or help from another service, the staff at the network would try to help them to get it and if necessary escalate the issue through their own management.

The registered manager explained to us that not everything could be managed in this way. For example if the needs of a person had implications for the level of support commissioned for them by the local authority then that would need to be referred to that authority. Also complex issues relating to capacity would need to be referred to the local social work service.

We saw that at the office base (which was within a day centre) people's personal records were stored safely in a locked room within another office. We saw that supervisors tended to access the files individually and return them after use so that they did not remain on desk tops where they might be seen by a casual visitor.

Because people who lived in the network lived in their own homes they also enjoyed a high level of independence. We saw examples of people's weekly plans which included visiting day centres, shopping, having lunch out and going to the pub, as well as undertaking household chores, cooking, and relaxing at home.

We saw that the network continued to care for people according to their own wishes where that included remaining in their own home when they were nearing the end of their life. We saw that there had been meetings at which people's views had been recorded about this. In the one instance we looked at we saw that the meeting had been held over a year ago and at a time when that person had been very ill.

Although this was not a formal best interest meeting we suggested that the registered provider included a review of this document when reviewing other care plans so as to ensure that it still represented the best interests of the person it related to. We also pointed out that the registered provider needed to ensure formal Do Not Attempt Resuscitation (DNAR) paperwork was available from a doctor in the event that this was still what the person wished.

We saw that those staff who were providing care for people nearing the end of their life had been provided with appropriate training for this purpose. We saw that other people had been helped to think about and make funeral plans where they wished to do so.

Good

Is the service responsive?

Our findings

We looked at care documentation for the people who lived in the network to see how the registered provider planned care to meet their needs. Each person had a care file which was maintained at the central office. The files were divided into sections including "My assessments" and "My care needs". On the basis of these relevant "My support plans" were then devised covering areas such as health needs and access to these, maintenance of social networks, responding to any behavioural issues, housing related support and independent living, choice and decision-making.

In each property each person had their own set of plans divided into three main files relating to care and support, medicines and finances. We talked to care workers about the files and it was clear to us that they used them regularly, knew the content of them and contributed to them as required. The care files we looked at were clear and legible. Staff told us "If anything changes we have to tell (the supervisor) and plan is changed. Then when something else changes the plan is changed again" and "I keep reading plans in case they change".

We saw that all these plans were written from the point of view of the person concerned rather than from the needs of the service. We saw that care plans had been regularly reviewed and updated. Staff told us that the plans had "all been talked through and gone over with (the people who used the service)". Because of the way they were written the care plans reflected the views of the people who used the service and were written from their perspective. We could see that where appropriate people's families had been involved in these discussions as well as the people themselves. When we talked with people who used the service it was clear that they were happy with the care that was provided for them on the basis of these plans. However the plans did not include any note confirming or explaining how, when or in what circumstances they had been discussed with either the service user or their representative. We raised this with the registered manager who undertook to look at this.

The plans helped care staff to work with people who might not be able to communicate verbally and so included information about how to tell if people were happy or sad judging by their non-verbal signs such as expression. We saw the care and supervisory staff interacting with people who used the service and saw that they were kind, friendly, knowledgeable and patient. Staff were enthusiastic about their work and said "I love it".

Although each of the support plans was reviewed annually we only saw evidence of one full review of a person's care. The registered manager explained that as people were no longer always allocated a social worker by the local authority the review process which had formerly been managed by them had reduced in frequency. One relative we spoke with felt that this had reduced the opportunity they had to contribute their view about a person's care.

People could influence their care in other ways. We saw that there were regular tenants' meetings held at monthly intervals. Minutes for these were produced in easy read and graphical format. We saw that they covered topics such as events that had recently taken place and future activities that people wanted to organise. Where the particular needs of one person might have implications for the others in the same house, this was discussed in a sensitive way. We saw that in one month the need to replacement household items had been raised and that in the following month there was a record that this had been actioned.

People could also make complaints or comments about the service. We saw that there was a service user guide which explained the service and that there was a document with a pictorial guide of who complain to if a person was unhappy with the service provided. This included supervisory staff within the service as well as the Care Quality Commission (CQC) We did not see that any complaints had been registered by people using the service, none had been received by CQC and none of those people or relatives we spoke with said that they had any to make.

We talked with one relative who told us about how when a person had experienced reduced mobility the network had been able to arrange a change of housing to one that was more adapted to their needs. We saw also that the network understood when it could no longer meet the needs of people when their health or other reasons meant they needed more care than could be provided safely.

Good

Is the service well-led?

Our findings

During our inspection we saw that there were positive relationships between the staff working in the network and the supervisors and the manager and that together the whole staff group focussed their work around providing support to the people who used the service. Staff spoke highly of the registered manager who had been in post for around nine months at the time of our inspection and shared his time with responsibility for another service within the same company. On the Provider Information Return (PIR) the registered manager reported that he had made 29 quality assurance visits in the last year.

Staff told us "He (the registered manager) has rung a few times and we talked. I can see him in the office if I go in". Other comments included "He was very supportive to me with a family review that was difficult" and "He likes things right. I like that in a boss". Staff told us that the registered manager was open to their suggestions and for example "We made suggestions about improving rotas and he said we could do it". During our inspection we saw that the registered manager made himself available to staff.

The registered provider had a system of named supervisors for supervision and we saw that care workers were similarly comfortable with them. Staff confirmed that they received supervision and appraisal and one member of staff told us "She's a good supervisor. When we phone up she's always there for us and helps us with any problems".

We checked the records of supervision and saw that this had taken place from time to time and included medicines competency checks, direct observation of practice including how staff related to people and management of finances. All of these involved a supervisor visiting the care worker in a person's home, making detailed notes about how they performed care tasks and then discussing these with the care staff with any recommendations for changes or further training.

We saw that there had been monthly visits to the service by the registered provider. These were recorded on a pro forma which allowed for a different focus for each month's visit such as health and safety, finance, infection control, and safeguarding procedures. We saw that these had been completed for each of the months prior to our inspection. Reports and actions were included in the accounts of these visits.

We were told that the service was introducing a similar monthly system of auditing led by the supervisors. We saw the results of these for the last two months. The audits were fully completed although in one instance we could not reconcile one detail of what was recorded with what we found in people's files. In addition audits of medicines and finance were undertaken nearly daily. We saw that these were detailed and rigorous and corrective action was taken where required.

We saw the minutes of monthly staff meetings which we were told were held by each team according to which house and group of people they worked with. These were written in a positive style and dealt with tenant issues, team and staff issues (including a team plan) training and health and safety issues, as well as providing briefing on any regulatory matters from the Care Quality Commission (CQC) or Supporting People which provided housing-related funding. We saw that there were also meetings of supervisors so that it was possible for information to be cascaded down from one level to another.

Registered providers are required to notify the CQC about any significant events which might take place in their service at any time. We reviewed each of the notifications we had received in the last year and were satisfied that they had been made correctly and that where required appropriate disciplinary proceedings were in hand.

The registered provider made performance information available across the range of activities which it managed so that the network could compare its performance with similar services. This meant that the registered manager received information about staff attendance, safeguarding and accidents and incidents so that he could monitor the service provided and take appropriate action where any significant variances or issues were evident.

We saw from the Provider Information Return (PIR) provided in advance that the registered manager had a programme of continuous improvement in place some of which included matters noticed at the inspection and commented on in this report. For example Disclosure and Barring Service renewals were scheduled to be completed in 2015. Care documentation was being revised with the introduction of an Anticipatory Care Calendar to allow for more proactive health care of people who lived in the network.