Real Life Options

Real Life Options

Inspection report

Suite 16, Pure Offices
Oxford House Parkway Court, South Oxford Business Park,
John Smith Drive
Oxford
Oxfordshire
OX4 2JY

Tel: 07726695850
Website: www.reallifeoptions.org

Date of inspection visit:
07 December 2016

Date of publication:
10 January 2017

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

We undertook an announced inspection of Real Life Options on 7 December 2016.

Real Life Options provides supported living in two supported living sites for people with learning disabilities in the Oxfordshire area. They also provide support for people in their own homes. At the time of our inspection four people were receiving a personal care service.

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.

None of the people who used the service were able to speak with us. Relatives told us people were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they able to recognise and report abuse. 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 action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

There were sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were consistently maintained. The provider had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Where learning needs had been identified action was taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

People had enough to eat and drink. People required minimal support with shopping and food preparation. People could eat independently.

Staff spoke positively about the support they received from the registered manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable

and there was a good level of communication within the service.

Relatives told us the service was friendly, responsive and well managed. The service sought people's 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.

There were sufficient staff deployed to meet people's needs.

Relatives told us people were safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place. People received their medicine as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

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 knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Real Life Options

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.

This inspection took place on the 7 December 2016. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in the office. This inspection was carried out by one inspector and an 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 care service.

We spoke two relatives and two care staff. We also spoke with the registered manager. We looked at four people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

None of the people who used the service were able to speak with us. People's relatives told us people were safe. Relatives comments included; "I feel my (person) is safe. He has a good team of carers" and "I feel my (person) is safe with his carers".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. Staff were also aware they could report externally if needed. Staff comments included; "I'd discuss any concerns with my managers or I could whistle blow" and "I would call my senior, my manager and the local authorities". The service had systems in place to investigate concerns and report them to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of 'slips and falls'. They used a wheelchair to mobilise and could transfer independently. Staff were provided with guidance on how to support this person safely. This included ensuring the person's wheelchair was charged and in full working order. Staff were also guided to ensure the person 'performs regular physio exercises' to 'strengthen their muscles'.

Another person was at risk of seizures. The person had not had a seizure for five years. This person received one to one support to manage the risk of seizures when bathing or showering. Staff were also advised to check water temperatures to ensure the person did not scald themselves. Staff we spoke with were aware of, and followed this guidance. One staff member who supported this person said, "[Person] has not had a seizure for a long time but we must still be alert and so he gets a lot of one to one care".

People's relatives told us staff were deployed effectively, were punctual and stayed the full time allocated. One relative said, "The continuity of day to day care is good. Staff are on time and stay till the next carer's come". Another relative said, "He has the same staff".

Staff told us there were sufficient staff to support people. Comments included; "We are not struggling so I would say yes, we have enough staff" and "I think there is enough staff, we always have staff available".

There were sufficient staff deployed to meet people's needs. The registered manager told us staffing levels were set by the "dependency needs of our clients". For example, where people required two staff to support them we saw two staff were consistently deployed. Staff rotas confirmed planned staffing levels were consistently maintained.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role and allowed the registered manager to make safer recruitment decisions.

People received their medicine as prescribed. Where people needed support we saw that medicine records were accurately maintained and up to date. Medicines were stored securely in people's rooms. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. One relative commented about management of medicines. They said, "The carers give him his medicines, I'm confident he is given the right medication".

Where people self- medicated an assessment had been conducted to ensure they were safe to take their own medicine. The assessment included when and how medicines were delivered from the pharmacy, staff checks to ensure delivered medicines were correct and staff witnessing people taking their medicine. This assessment also covered homely remedies and medicines to be taken as required. Where relevant staff were provided guidance relating to medicines.

We spoke with staff about medicines. Comments included; "I do help clients with medicines. I am trained and checked so I am very confident with this" and "Yes I help some people with medicines. I have been trained and they do check my competency".

Good

Is the service effective?

Our findings

People's relatives told us staff were well trained and supported people effectively. Relatives comments included; "My (relative) has unique care needs and I feel the carers understand his needs" and "I feel the carers are matched well, the carers do understand his needs".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction programme linked to the Care Certificate and completed training when they started working at the service. The Care Certificate is a set of standards that social care workers adhere to in their daily working life. It is the new nationally recognised set of minimum standards that should be covered as part of induction training of new care workers. This training included fire, moving and handling, medicine competency and infection control. Staff also completed three days shadowing an experienced staff member before working independently. We spoke with staff about training. Staff comments included; "Absolutely brilliant, really good" and "I thought the training was very good, no problems".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one staff member had requested 'forensic training' and this had been provided. We spoke with staff about the support they received. One staff member said, "I do get supervisions and find them really useful. We not only discuss my work but client's progress as well. I am also able to discuss how I am getting on with my training".

Staff were also supported through observation of care practice. Senior staff observed staff whilst they were supporting people. Observations were recorded and fedback to staff to allow them to learn and improve their practice. Observations were also fed into staff supervisions. For example, it was identified one staff member required some further training and we saw this training was planned.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to make these decisions when needed. When people lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. The registered manager told us they continually assessed people in relation to their rights and they were aware that applications must be made to the Court of Protection if their rights were affected. They were also aware the court of protection was the decision maker relating to depriving the person's choice when living in the community. At the time of our inspection two Court of Protection authorisations were in place.

Where people were thought to lack capacity, mental capacity assessments were completed. For example, one person's capacity to make a decision about a risk had been assessed by healthcare professionals and an application to the Court of Protection had been made. The Court of protection had approved the conditions of the person's support. The person's best interests had been considered throughout the process.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "The act helps me with understanding around clients decisions. It helps me to support them if they are struggling to make any decisions" and "I always assume they have capacity to make decisions and I try to give them choices". One relative commented, "I feel my (person) has choices, and they (staff) encourage him to make decisions".

We asked staff about consent and how they ensured people had agreed to support being provided. One staff member said, "One client always gives me a thumbs up as they have trouble speaking, the others understand more easily but I still go slowly, step by step to be sure".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans.

People had enough to eat and drink. All the people using the service were independent with preparing and eating their meals. We could not identify any risks associated with eating and drinking. We asked staff about people's ability to prepare and eat their own meals. Comments included; "They (people) are all pretty independent with food and drink. Sometimes they need a little encouragement but otherwise there are no problems" and "Most of the time I am just making sure they are safe when preparing food. Burns and scalds, that type of thing. I take them shopping and they prepare the weekly menu with a little help but they eat independently".

Good

Is the service caring?

Our findings

Relatives told us people benefitted from caring relationships with the staff. Comments included; "Overall staff are caring and kind" and "They are all very kind staff. The carers have turned his (person's) life around".

Staff spoke with us about positive relationships with people. Staff comments included; "I really enjoy this work. I can tell if a client is worrying, upset or unwell and then I can act. Yes, we care" and "Yes I think I do care. They (people) are lovely".

People's dignity and privacy were respected. When staff spoke about people with us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. One person's relative commented, "I find all staff respectful". A community healthcare professional contacted prior to our inspection stated 'people were treated with dignity and respect' by staff.

We asked staff how they promoted, dignity and respect. One staff member said, "I'm confidential, I close doors and curtains and make sure they are comfortable with what we are doing". Another staff member said, "I speak to clients with respect. I keep it all confidential and offer choices".

Staff actively encouraged and supported people to be independent. For example, one person was supported to attend college. One staff member said, "I get them to do what they can do so they retain those skills". Another staff member said, "I have shown one client how to dry their back. They were so happy to be able to do this".

The service supported people to remain independent. Care plans highlighted people's capabilities and where they required support. For example, one person could get up in the morning independently but required 'prompting' to wash their hand after using the toilet. Another person was able to wash independently but sometimes needed 'help with the hand washing liquid'. Where they were able people were also supported to take their own medicines. One relative commented on how the service promoted the person's independence. They said, "They encourage my son to go to different places".

People and their relatives were involved in their care. We saw people were involved in creating their care plans and in reviews of their care. People had signed and dated their care plans. Documents were written in an easy read, picture format enabling people to understand and be involved in decisions. We asked staff how they involved people in their care. One staff member said, "I offer choices and get them to be part of what we are doing. They are involved in making menus and going shopping and I encourage that".

The provider ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office. The provider's policy on confidentiality was available to staff who had read and signed the policy. The policy provided staff with guidance relating to protecting people's confidential information. Staff we spoke with were aware of, and adhered to the policy.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to receiving a service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's 'what's important to me' document read: 'my family, and getting in touch on a regular basis'. Another person had stated that 'cricket, playing pool and board games' were important to them. Staff we spoke with were aware of people's preferences. We also saw their preferences listed on weekly activity sheets.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had asked for staff to give them 'the space and time to contact my parents'. Another person wanted to be 'involved in planning my activities'. Records confirmed these requests were being respected. People's care plans were regularly reviewed and the person signed evidencing they had been involved in the review. We spoke with relatives about care reviews. One relative said, "I am involved with annual reviews ". Another relative said, "We are invited to review meetings".

Care plans were personalised and reflected people's needs and preferences. For example, one person had difficulty verbalising and used signs and body language to communicate. Their care plan listed behaviours that indicated to staff the person's mood and state of mind. For example, if the person clapped their hands and stamped their feet they were confused or anxious. To calm the person, staff were guided to reassure them and 'explain things slowly'. Another person' raised their voice, flailed their arms and pointed' indicating they were angry or upset. Staff were guided to reassure the person, listen and find out 'what is bothering' the person.

Where people could present behaviours that may challenge others, 'positive behaviour plans' were in place. These provided staff with guidance on how to support the person achieve 'positive outcomes'. For example, one person's plan stated that staff should 'ensure the person is safe' and 'maintain a distance and speak calmly to [person]'. Staff were also guided to 'distract' the person by making a 'cup of tea or coffee'. Staff were also provided with a list of 'do's and don'ts' to de-escalate any situation. For example, 'don't smile and don't point your finger'. Staff we spoke with were aware of these strategies.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they assisted people with their personal care to suit their individual preferences. Staff comments included; "It is care you give someone that is tailored to their particular needs or wishes" and "This is care for that individual and no one else".

Where people attended hospital their care plans contained a 'hospital passport'. This provided hospital staff with important information about the person. The information included personal information, a brief medical history, the person's current condition and any allergies or significant information. This meant hospital staff had the information they needed to respond to the person's needs safely and reduced the

need for hospital staff to search for any relevant information.

People's changing needs were responded to by the staff. For example, one person was struggling to live with other people. Their needs and behaviours were reassessed and as a result the person was moved to their own bungalow. Records showed the person was involved and consulted with this move and they were now making positive progress. Another person was noticed to be 'wobbly' and less active after taking their medicine. The person's medicine was reviewed and the prescribing psychiatrist reduced the dosage. Records showed that over a short period of time this person's wellbeing improved.

People were encouraged and supported to engage in activities and maintain community links. A weekly planner of people's activities were created by people and staff. Activities listed included; preparing meals, exercise, going to college and shopping. Activity plans also had built in time for spontaneous activities for people to fill. For example, watching TV, playing board games or going out. The registered manager spoke with us about one person's activities. They said, "[Person] loves going out. He uses buses and trains; he's very good and completely safe. He really enjoys his trips".

People and their families were provided with details of how to raise a complaint. Details on complaints were held in the 'service user guide' which was given to people and their families when they joined the service. The guide was written in an easy read picture format that people would be able to understand how to raise a concern. Included were contact details for the Care Quality Commission (CQC), the local authorities disability team and Real Life Options whistle blowing line. The service had no formal complaints recorded. The registered manager said, "We deal with issues long before the formal complaint process is reached".

Relatives told us they knew how to complain and were confident action would be taken. One relative said, "I can bring up any concerns and they will action them". Another said, "We are encouraged to contact the office with any concerns".

People's opinions were sought and acted upon. Regular surveys were sent to people and their families to obtain their views on the service. We saw the results of the last survey. The responses were positive with no issues raised. The registered manager also conducted one to one meetings with people's relatives to deal with any raised issues. For example, one meeting discussed a person's behaviours and how these were being used to manipulate relatives and staff. Further discussions to place which included the person and a positive outcome was achieved.

Good

Is the service well-led?

Our findings

We asked relatives about the service and their views on communication with the registered manager. One relative said, "I feel the agency is well led, but feel communication recently has dropped and this makes me uneasy". Another relative said, "I don't know who the manager is and I feel the communication with the office is poor". We spoke to the registered manager who said, "I don't understand this, my details have been sent to all service users relatives and I believe I have spoken to all of them. Even if I am out of the office they all still have my mobile number. I will look into this as I think they are confusing me with another manager".

Staff told us they had confidence in the service and felt it was well managed. Staff comments included; "[Registered manager] is very good, approachable and supportive. He gives me choices and solves my problems" and "He is very open and supportive. He wants all staff to work to the best of their ability. It has been all good here so far".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. The registered manager and staff spoke openly and honestly about the service and the challenges they faced. One staff member commented, "I think it's a good company to work for. No secrets at all".

The registered manager told us their vision for the service. They said, "These people need our support but at the same time I want them to be independent. One of our service users wants to enter the next Para Olympic games and we are supporting them to do that. I also want my staff to progress and they should be given the tools to do that".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns and trends. This information was also overseen by senior management. For example, one person was independently visiting a friend. They slipped of a chair and fractured their leg. The investigation into this incident noted this was an unwitnessed fall and concluded this was an unforeseen and isolated incident. We also saw the person was spoken with about the incident and was provided with additional guidance about safety when out on their own. Investigations into accidents and incidents included actions to be taken to reduce the risk of reoccurrence and improve the service. For example, following one incident, actions identified the person's care needed a review and training for a member of staff. We saw that both these actions had been completed.

Staff told us that learning from accidents and incidents was shared through staff meetings and briefings. One member of staff said, "Our line managers inform us and we receive text messages to update us. We use a communications book and we share any learning at handovers as well". Another staff member said, "We frequently use the communication book plus we have staff meetings and handovers. Everyone is well informed".

Staff meetings were held and recorded and we saw staff discussed people's needs, received updates and shared learning through these meetings. 'Management' meetings were also held where senior staff

discussed people's care and activities they engaged in. For example, 'forum' days were organised through these meetings. 'Forum' days celebrate a particular date or event with activities for people. We saw one forum day was held in October to celebrate Halloween. All aspects of the day were discussed at this planning meeting, including risk assessments for people relating to the planned firework display. Records showed the Halloween forum day was a success.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including risk assessments, care plans, training and medicine records. Audit results were analysed and resulted in identified actions to improve the service. For example, one audit identified certain guidance relating to a person's medicine needed to be reviewed and updated. We saw this had been completed. The provider also conducted regular audits relating to health and safety and quality.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.