Care Quality Commission

Southside Partnership

Wandsworth Adult Placement Service

Inspection report

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Ratings

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

Overall summary

This inspection took place on 14 and 22 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a shared lives care service and we needed to be sure that someone would be in. At our previous inspection on 15 October 2013 we found the provider was meeting regulations in relation to the outcomes we inspected.

Wandsworth Adult Placement Service, known as Shared Lives, provides personal care and accommodation for people of all ages with learning disabilities. People who use the service can access short term, long term and respite care within a family home. They also offer an out of hour's emergency service. The manager told us that a number of carers now lived on the South Coast and in other parts of the country. At the time of our inspection,

Summary of findings

there were 27 permanent placements, one respite and one day support. They primarily support people with learning disabilities and some have additional needs such as sensory impairments.

There was a registered manager at the service; however she was not managing the service at the time of our inspection. Another manager was in post and they were in the process of registering with the CQC at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service told us that carers looked after them and treated them well. We found carers were familiar with safeguarding procedures and knew what steps to take to keep people safe.

Risk assessments were carried out which helped to ensure that people were able to take part in daily activities in a safe manner. Risk assessments included a risk management plan which identified the level of risk and contained an in-depth management plan.

People received their medicines safely and received ongoing health care support. Guidelines were in place to ensure people received their medicines correctly and carers completed medicine records when they administered medicines. People had health action plans and hospital passports in place which had been recently reviewed to ensure that people's health needs were met.

The provider had developed a new induction programme which had been implemented for all new staff from June 2015. However, we found that there were gaps in the mandatory training that carers had received.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and its application. Carers were aware of the importance of asking people for their consent to care. The provider had submitted applications to the authorising body where restrictions were deemed necessary to keep people safe.

Care records were person centred and developed with the help of an in-house intensive support team. They helped to ensure behaviour support plans were in place and specialist advice was available to support carers.

Quality assurance was central to monitoring the way service was run. A newly recruited head of quality had put in place a number of systems to monitor and measure quality across the organisation. A quality framework had been developed, bringing together a range of quality outcomes from external organisations and implementing them within the service and seeing what areas needed to be improved. Feedback was sought from people in a manner that was accessible to them.

We also found that some carers did not have their DBS checks renewed every three years as per the providers own policies. We have made a recommendation with regards to carrying out DBS checks on members of a carer's household.

We have found a breach of regulation in relation to staff training. You can see what action we told the provider to take at the back of the full version of the report..

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?

Requires improvement

The service was safe. Although robust recruitment checks were carried out on new carers, some carers had not had a renewed DBS check after 3 years.

Carers were aware of what steps to take if they suspected people were at risk of harm.

Risk management plans were in place that helped to ensure people were kept safe.

People received their medicines safely.

Is the service effective?

Requires improvement

The service was effective. Although carers told us they felt supported, they did not always receive mandatory training at regular intervals to ensure their knowledge and skills were up to date.

The provider was meeting its requirements in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

People had their healthcare and nutritional needs met by the provider.

Is the service caring?

Good

The service was caring. The provider matched people with carers who met their needs and looked at people's backgrounds or shared interests when allocating carers.

Carers were careful of respecting people's privacy and dignity when carrying out personal care.

Is the service responsive?

Good

The service was responsive. People had access to activities of their choice and were given support by carers to take part in these.

Care plans reviews were person centred and were reviewed regularly.

People were given information on how to raise concerns in an accessible format. People were able to raise concerns in key worker meetings.

Is the service well-led?

Good

The service was well-led. People and carers said there was an open door policy at the service and they felt comfortable approaching managers.

Quality assurance audits were thorough and feedback surveys were carried out.

Wandsworth Adult Placement Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 22 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a shared lives service and we needed to be sure that someone would be in. The inspection team comprised two inspectors.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection, we spoke with two people using the service. We spoke with two carers, the registered manager, a service manager and the head of quality. We looked at three care records, four staff files and other records related to the management of the service including training records, audits and quality assurance records.

Requires improvement

Is the service safe?

Our findings

We found that although there were robust recruitment checks in place to help safeguard people, ongoing criminal record checks were not always up to date. The provider carried out Disclosure and Barring Service (DBS) checks for all members of the household where an individual was placed. We saw that DBS checks were not always kept up to date in line with the provider's guidelines, although the provider had a robust method for tracking these. We saw that five carers were working without an in date DBS checks according to the provider's own policy for requesting DBS renewals after three years. We also noted that it was still policy that all members of the household have a DBS check, although this may no longer be appropriate.

The provider followed established and accepted practice included in guidance from Shared Lives Plus in the recruitment and approval of shared lives carers. This consisted of an assessment process that included a demonstration of carers' skills, knowledge and abilities to support people using the service, assessment of provision of a safe and suitable homely environment and completion of a pre-placement assessment programme. The provider used a shared lives panel that reviewed this and made recommendations about the decision to approve carers to ensure that they were suitable to provide support to the people using the service.

People using the service told us they felt safe. They commented, "We would come here (the office) if we were worried, or go to my carer", "I feel safe" and "I would go to manager if I can't get hold of carer if I didn't feel safe. They help us out with our money." One carer said "They have an open door policy, and they encourage us to bring clients into the office so they don't feel intimidated when they come in for meetings."

Carers had received safeguarding training and had a good understanding of safeguarding. For example, they knew about different signs of abuse and that they must report any concerns to the office. There were safeguarding policies and procedures in place and contact numbers for the safeguarding team were available. There had been some safeguarding concerns at the service within the past year. We noted the provider had responded to these in a timely manner, worked with the local authority to investigate them and made changes to try and ensure they did not happen again. For example, risk assessments had been updated and more training provided. In one incident, potential financial abuse had been noted on a routine monitoring visit by a care co-ordinator. As a result of this, tougher checks were put in place and the provider clarified expectations for carers about which financial records were needed. The provider had included clear information for carers in their newsletter outlining expectations about what records had to be kept depending on people's capacity to understand and manage their own finances. The manager told us financial records were brought back to office for them to sign. Safeguarding concerns were discussed in annual carer review meetings.

There was an open door policy at the service where people were able to come into office and report concerns, which is how one of the previous concerns was identified. The provider had a whistleblowing policy and a dedicated number that was provided at training and support groups.

The provider had set up a user's group every month, which involved playing games and discussing topics such as a community nurse led discussion on sexual health, being safe on the street and hate crimes. This demonstrated that the provider took steps to ensure people were aware of dangers in the community to help ensure their safety.

Risk assessments were individualised for people and were reviewed every six months to ensure they contained up to date information. Each person had a 'person centred risk management plan' based on specific circumstances, these identified the level of risk and contained an in-depth management plan to mitigate the risk to ensure people were safe when taking part in activities. A risk log was also maintained which was a record of any activities that contained some risk to people but did not require a specific management plan because existing guidelines/practices were sufficient to ensure the activity was safe.

Carers told us that regular safety checks took place. Comments included, "They do a home visit and health and safety checks" and "We have regular home visits, including unannounced checks." In annual carer reviews, the safety of the house was checked, including gas, electrical and fire checks.

Carers also said they encouraged positive risk taking. For example, there was an agreed time to contact the police to report a person missing if they went out independently, based on their individual needs. The manager said they also put specific risk assessment in place for people in

Requires improvement

Is the service safe?

response to incidents to try and mitigate any identified risks to people's safety. One carer said, "They're adults, you can't stop them, but the longer they've been with you the more they'll trust your advice" and "We don't have a set time for getting home, we encourage them to text if they're going to be home late."

Behaviour support plans were in place to manage behaviour that challenged the service. These were comprehensive in scope and identified potential behaviours, the reasons they occurred and plans to reduce the likelihood of them reoccurring. They gave clear guidelines on what steps carers could take, for example to use short sentences, use objects and gestures, and avoid negative statements. They also gave information about strategies that worked and did not work and a response plan if people started to display behaviour that challenged.

One person told us, "She helps me with my medication, she's good at that." Care plans had descriptions of people's medicines and how they liked to be supported with these. People received their medicines in a safe manner and carers kept accurate records. We reviewed samples of medicine administration records in the office that had been brought in and saw that carers completed these correctly. Each person had a medicines profile which was written in an easy read format. These gave details of the medicines taken, the dose and what they were used for. These had been reviewed within the past year.

We recommend that the provider seeks up to date information from a reputable source about whether DBS checks need to be carried out for all members of a household rather than just the shared lives carer.

Requires improvement

Is the service effective?

Our findings

Although, the provider had thorough records of training received by carers we found that they were not fully complying with their own requirements on renewing mandatory training. For example, out of 63 carers, only 40 had up to date fire safety training, 39 had health and safety training, 47 had received training in how to safeguard adults from abuse and 51 had received first aid training. Training records also showed that less than a quarter of carers (17 out 63) had had training on the Mental Capacity Act 2005 (MCA) in the past 5 years.

We found this to be a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and support coordinators managed the induction and training of new carers as part of the assessment process. The provider had implemented the new 'Care Certificate' and adapted it to meet the needs of the service to provide a comprehensive induction programme for carers.

The provider had developed three modules and workbooks taken from the 15 standards of the Care Certificate for new starters to obtain this qualification. This had been implemented for all new staff from June 2015. The induction programme lasted for three months and new staff worked through the training modules and workbooks, overseen by their line manager who signed them off at the point of completion. The modules were 'Me and Certitude', 'Me and the people I support', and 'Me and working safely'. This showed staff were provided with knowledge and skills in order to help them understand the values of the organisation and safely meet the needs of the people they supported.

The manager showed us plans that were in place to overhaul the training programme for carers to run for two years, covering six modules. These modules were called, quality of life, person has control/independence, person has a safe life, first aid, communication and roles of a shared lives carer.

Shared lives carers groups were held on the south coast and in London, these groups were a source of support for shared lives carers. Carers also attended an annual quality action/appreciation day, carried out by external facilitators.

Carers said these groups were useful, one carer said, "We support each other". There were also separate yearly reviews for carers, and we saw evidence that these were being carried out.

Carers said they made sure people made decisions for themselves wherever possible but were supported when doing so. They recognised that people they supported had capacity to make their own decisions. One carer said, "In some areas yes, in some not so sure, you can tap into the office to find out." We found that carers recognised the importance of asking for people's consent before supporting them and also understood their responsibilities under MCA and Deprivation of Liberty Safeguards. Carers said they learnt about what's important to people during their person centred reviews and the reviews gave people the opportunity to consent and give their views on how they liked to be supported.

The manager told us they had revamped some of the records, including sections around decision making. We saw that person centred plans, included detailed information about the areas of daily living people were able to make decisions about, such as their finances. Person centred plans had very detailed descriptions of people's ability to make decisions in various areas. Hospital passports showed evidence that issues of consent were considered for the benefit of medical staff. However, the plans were in an electronic format, and as such there was no evidence that people who used the service had agreed to the content as they were not signed. The manager told us this was routine, but that people were given their own copy of the plan after the review.

The Care Quality Commission (CQC) is required by law to monitor how care providers operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

We discussed the requirements of the MCA with the manager. He demonstrated a good understanding of the process to follow where it was thought that a person did not have the mental capacity required to make certain decisions. Two applications had been submitted to the authorising authorities to formally deprive people of their liberty, these were for people under constant supervision who were unable to leave home unaccompanied safely.

Requires improvement

Is the service effective?

People's dietary needs were being met; none of the people we spoke with had any specific dietary requirements. They told us, "Mainly I make food and go out by myself" and "We get to eat what we want where we live."

We found that people's healthcare needs were being met. One person said, "My carer comes to appointments with me when she needs to." Evidence was seen of regular check-ups with health professionals such as GP's, podiatrists and opticians. People had hospital passports and health action plans in place that had been reviewed within the past year. The aim of a hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

Health action plans recorded the level of support needed in relation to a person's health needs. We also saw evidence that where specialist input was required, carers acted to ensure this was met. For example, one person who enjoyed swimming was referred to a physiotherapist who carried out an assessment and developed a tool to support this activity.

Good

Is the service caring?

Our findings

People had positive things to say about the caring attitude of staff. People told us they were made to feel part of the carer's family. Comments included, "I get to speak up", "They always listen to what I say" and "I like everyone who is there now." Carers also said they treated people as a member of their own family, one carer said, "We recognise birthdays, make them feel like part of the family." Another said, "They feel at home."

People told us that carers respected their privacy. One person said, "They always knock before opening my room" and another commented, "My foster mum lets my partner stay." Carers were aware of the importance of respecting people's privacy and dignity when supporting them with personal care. Comments included, "It's their own room, I wouldn't want anyone to barge in without knocking.

Each person had support guidelines in place so carers had access to information about people's preferences in relation to their night time routine, behaviour and personal care. Care records contained people's specific needs covering aspects of their daily living that were important to them. Care records were written in plain English and were person centred.

Care plans had detailed descriptions of people's wishes for the future, and reviews people were supported to identify goals and how they may be able to fulfil them. The provider had a system in place for monitoring progress throughout the year and had introduced annual person centred reviews to look at people's lives holistically. These were carried out by a specialist internal team of person centred planning facilitators. We saw review minutes that confirmed that these were taking place. People had a communication profile in place, giving guidelines to carers about the best way of communicating with them..

People using the service told us they led independent lives. Comments included, "I'm independent", "[my carer] lets me do what I want, I just say what time I'll be back" and "They've taught me a lot." They said they were given opportunities to have a say about their support provision and were invited to shared lives panels. People made comments such as, "They're good at asking me to come in for interviews, they include us in it", "It makes us feel more confident" and "Sometimes we put them on the spot." A carer said, "They ask us to be on the panel, carers and clients are asked." The manager confirmed that they invited people to be on the shared lives panel when recruiting new carers.

The provider matched people with carers who met their needs and people chose their respite carers. They gave us reasons why they liked to visit particular carers, due to similar backgrounds or shared interests. This demonstrated that the provider took steps to ensure people's cultural and social needs were met.

Good

Is the service responsive?

Our findings

We found that the service was responsive to people's changing needs. Shared Lives arrangements were organised using a formal matching process. This involved people and carers getting to know each other at their own pace, before making any long term commitment to sharing a home. The provider took steps to ensure the carer was able to meet the identified needs of the person placed with them and that they had a rapport with them. The matching process took account of the person's assessed needs and wishes, the knowledge and experience of the carer, personal interests and the cultures and/or faiths that were important to the person and the carer. Staff said there was a very thorough matching process to match common interests, experience, background and household make up. One staff member said, "If we can't meet needs we don't proceed."

Once people had been matched with a shared lives carer, they were assigned a link worker who took a lead in supporting them and managing their needs, however the manager acknowledged that due to problems with recruiting link workers they were not meeting their own expectations about the frequency of link worker visits. This was reflected in feedback that we received from people who said, "I got to choose my link worker", "I see my link worker if I'm in trouble" and "I don't have 1:1s often with my link worker, I would like to see them more."

The provider had a person-centred development manager who facilitated the development of person centred care plans and also took a lead on training staff within the organisation. Care plans were reviewed by the person-centred development manager, on a yearly basis or more often if circumstances changed.

We looked at a sample of care plans which were held electronically within the office and also in people's homes. We reviewed some person centred plans and saw that they had been developed with the person in mind, rather than being task orientated. Information included important family members, friends and others in people's lives, what a typical good and bad day looked like, what was important to and for people, their hopes and dreams and how carers could support them to maintain their independence. The manager said that the person centred reviews were successful and allowed them to focus on people's changing needs. He said, "You find a label and assumptions stick to people, people's wishes change. We take an open mind and don't make assumptions." He gave us examples of where a person centred review had resulted in a positive impact on the support that people were given.

Working guidelines were also in place for medicines, finances and other tasks such as preparing meals. Behaviour support plans identified the behaviour, prevention plans, effective strategies for supporting people, response plans and monitoring of behaviours. Outcomes and goals monitoring were looked at during monthly link worker meetings. Some of the entries that carers had entered for goal monitoring said ongoing or no change, although we saw that people were being supported to achieve their goals. Therefore the records did not always reflect how carers were supporting people to achieve their goals and did not always include the views of people using the service.

We saw that people led independent lives and were supported to take part in activities of their choosing. One person said, "I tell [my carer] where I want to go, or he says would you like me to take you to x?" Carer's comments included, "We have a multicultural household, ask everyone's favourite food, make it together", "We promote independent living skills, they're free to buy takeaways and bring it home, it's their home as well." One carer told us they worked with one person who loves trains, and were able to support him to gain an apprenticeship with TFL. A carer told us they had identified that one person liked "to party and likes to go on holiday" so they suggested a holiday to Ibiza which was being planned.

We found that the provider responded to people's complaints in a timely manner. Formal complaints went directly to the chief executive who assigned the complaints for a manager to investigate. People were given details of how to raise concerns and complaints in an accessible format and, a complaint monitoring form was used to record all activity related to any complaints that had been received. One person said, "If I had a complaint I'd go to [manager] or I'd come [to the office]." A Carer said "If they're not happy we encourage them to talk about it, and say if you're not happy you need to say you're not happy." Carers gave us examples where they had encouraged people to raise concerns and these were acted upon. Records showed that where people had complained; the provider had taken their complaint seriously and investigated it thoroughly.

Good

Is the service well-led?

Our findings

People who used the service said there was an open door policy and that they were able to visit the office anytime, even for a brief chat. We saw this in practice on the second day of our inspection. One person said, "Sometimes I get pot noodles and they let us in the kitchen." Staff also said they felt well supported, were given autonomy and were able to have an open dialogue with the manager. They told us, if the manager was not in, they would not hesitate to approach the service manager. One carer said, "You're not left by yourself, there's a team that's involved looking after you. They try to make you feel a part of it." Carers said the out of hours system worked well.

The provider had an intensive support team who had been in post for over a year and provided support to help meet people's individual needs. The team consisted of a range of professionals including a qualified learning disability nurse, qualified Makaton trainer and a specialist in intensive interaction, person centred development manager, behaviour support practitioner and a positive behaviour support manager who was a qualified Board Certified Behaviour Analyst (BCBA). This helped to ensure that people received highly personalised care and support that met their needs.

The provider had effective systems in place for disseminating information across the organisation about good practice and how to monitor it. A good practice intranet link and an email was sent out to staff every week highlighting any good industry practices. A system called 'Certitrack' was used for high level monitoring of the various supported living schemes. This was used to monitor individual outcomes for people and care records monitoring.

The head of quality carried out high level monitoring of audits carried out by service managers to help ensure any identified actions were followed up. The head of quality had also recently developed a 'Certitude quality framework' to look at the things they did, how well it was done and how it could be improved. The quality framework bought together a range of quality outcomes from organisations such as the Care Quality Commission (CQC), Quality Assurance Framework (QAF), The National Institute for Health and Care Excellence (NICE), and Think Local Act Personal (TLAP) into three main quality outcomes to measure their own quality against. QAF allows community and voluntary organisations to look at their strengths and weaknesses and continuously improve their quality. TLAP is a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support. The three quality outcomes for Certitude were based on engagement, inclusiveness, and robust governance and commitment to continuous improvement. We were given a practical implementation of how this worked through a review carried out by the health and safety committee after some medicine errors, to minimise these from occurring in future. The first quality framework gave guidance on new legislation around food allergy, and good Do Not Attempt Resuscitation practice. This showed the in-depth way the provider benchmarked the quality of care for people using the service, in accordance with reputable national guidance

The provider was a member of shared lives plus which is the UK network for small community services, including shared lives carers and schemes. This demonstrated its commitment to providing a service that met the needs of people

Annual satisfaction surveys were sent out to people at the end of September, the results of which had not been fully analysed by the time of our inspection. A range of accessible methods were used to gather people's views including giving people an easy read version, carrying out face to face interviews and using an online version of the survey.

A staff survey was also completed which had a good response rate of 69% overall. We looked at the results of this and saw that staff gave positive feedback in relation to leadership such as their trust and confidence in the leadership team and their ability to act on results. Staff were also satisfied with the training and coaching/ mentoring opportunities available. They were less satisfied with the induction but we saw that the provider had made changes to the induction, which had not yet been implemented for long enough to gain staff feedback

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed did not receive appropriate training to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).