Independent Living Solutions Limited

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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**

Summary of findings

Overall summary

Independent Living Solutions provides specialist care support packages to people living in their own home. They work with people who have an identified need such as, spinal cord injury, brain injury or cerebral palsy. They provide a case management and rehabilitation service to children and adults. At the previous inspection conducted in 2013 all standards inspected were met.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The questionnaire feedback received from staff and community professionals employed/used by the agency indicated that people were not always safe from abuse. However, people responding to questionnaires told us they were safe when staff were present. The person we visited responded in a positive manner to the staff on duty. The members of staff we asked knew that where there was alleged abuse the expectations was to report abuse to the lead safeguarding agencies.

The registered manager said staff attended training relevant to their role, staff told us the quality of the training provided needed improving. Safeguarding of vulnerable adults from abuse training was set as mandatory training by the provider for all staff to attend. The email dated 4 January 2017 updated professional mentors that annual webinar safeguarding training instead of three yearly training was to be completed by case managers. New staff had an induction when they started work for the agency. New staff were provided with material that followed the care certificate course for example, booklets and all areas were covered over one day. The registered manager said case managers "went through" the training material with new staff.

The registered manager said mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) applications were made by other professionals such as court of protection officers. However, the supervisory body was not contacted by the registered manager to inform them that the care regime deprived the person of their liberty. For example, where bed sides were used.

While quality assurance systems were in place and clinical audits strategies were identified as an area for improving, action plans were not in place on how the delivery of care was to be assessed and on how it was to improve. Staff and community professionals employed/used by the agency told us through questionnaires that the quality of training needed improving.

Care management plans were in place and were detailed for some people. Care plans included the aspects of care the person was able to manage for themselves. The care plans that we saw in one person's home was not updated when they moved house including when there was a change of staff. For another person the care plan was not fully person centred. The documented language seen in contact notes used by a

member of staff about one person lacked insight into their cognitive impairment.

The company employed provide the funds to provide personal care will determine the staffing levels needed for the care package. Members of staff we spoke with said the staffing levels were appropriate to meet the needs of the person they delivered personal care for.

Medicine systems were safe. Medicine Administration Records (MAR) were used to record the medicines administered. Medicines were stored safely and systems were in place to monitor medicine management.

People and relatives said the staff were caring and kind. The staff we spoke with told us the manner in which the person was enabled to make decisions. We observed members of staff interact well with the person. These staff knew the person's preferences and sat at the person's level when they interacted. Community professionals employed/used by the agency said the staff always followed their advice and guidance. They said the service tries hard to continuously improve the quality of care and support they provide to people.

We have made a recommendation about the provider gaining from a reputable source how to implement the principles of the Mental Capacity Act.

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 not consistently safe.

The people responding to questionnaires said they were safe with agency staff. The person we visited made vocal noises of enjoyment when staff were present. However, staff and community professionals were not confident in their responses to indicate that people were safe.

Risk assessments had been completed where potential risks had been identified. Staff knew the actions needed to minimise these risks.

Medicine systems were safe which including storage of medicines. Staff signed medicine record charts to indicate the medicines administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff said they had not received Mental Capacity Act (MCA) training and community professional employed/used by the agency said in questionnaires that managers lacked an understanding on the principles of the MCA.

Staff told us the quality of training needed improving.

Staff supported people with their dietary requirements.

Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring. They told us the staff respected their rights.

Members of staff were knowledgeable about people's needs and how to meet their needs in their preferred manner.

Is the service responsive?

Good

The service was mostly effective

Care plans overall were person centred as staff were given guidance on on how people liked their care needs to be met. However, for one person the care plan was not updated since moving house or staff changes. For another person the care plan lacked detail.

People told us they knew the complaints procedure and who to approach with their concerns.

Is the service well-led?

Good

The service was well led.

The quality assurance systems in place were not fully effective as plans on how to improve the service were not in place. People, staff and community professionals employed/used by the agency said their views about their agency was not sought.
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Members of staff knew the values of the agency and worked well together to provide consistency of care to people

Independent Living Solutions Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2001

This inspection took place on 12 and 16 January 2017 and we gave the registered manager short notice of the inspection. The provider was given 48 hours' notice because the service provides a domiciliary care service and we wanted to make sure the manager would be available to support our inspection or someone who could act on their behalf.

The inspection was conducted by one inspector. The provider completed a Provider Information Return (PIR) with updates as requested. 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 also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We visited one person and we also spoke to the two staff on duty and the relative. We also used questionnaires to gain feedback from people about their experiences of the agency. We gained feedback from staff and community professionals employed/used by the agency from questionnaires and we also the registered manager and other senior managers. We looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

People using the service were protected from abuse because staff knew how to identify abuse and the action they must take to report abuse. The relative of the person we visited said their family member was safe in the presence of the staff. The members of staff we spoke with described the types of abuse and the actions they would take for allegations of abuse. They said the appropriate safeguarding teams would be contacted to raise an alert. The people and their relative responding through questionnaires said they felt safe with the staff.

We received some negative feedback from staff and community professionals employed/used by the agency regarding people being safe from harm and abuse. 69 per cent of the community professionals employed/used by the agency said people who use this care agency were safe from abuse and or harm from the staff. This meant the staff and or community healthcare professionals employed/used by the agency were not confident people using the agency were fully protected from potential abuse.

95 per cent of staff that responded to questionnaires knew the actions they must take where abuse was suspected, 92 per cent of the staff said people who used this care agency were safe from abuse and or harm from the staff of this service. We discussed the response received with the registered manager. The registered manager said "safeguarding had been covered during the support workers induction in line with the requirements of the care certificate".

Risk assessments were combined with care plans and kept electronically. The registered manager told us hard copies were also kept in people's home. The potential risks were identified and the actions needed to minimise the risk. For example moving and handling risk assessments. Members of staff we spoke with knew the actions needed to protect from harm the people who they delivered personal care. For example sensors were used in bedrooms to alert staff of movement and overhead tracking was used to support the person with transfers from the chairs to bed.

The people responding to our questionnaires told us they received care and support from familiar, consistent care and support workers, their carer and support workers arrived on time and they would recommend the service to another person. The relative of the person we visited said sufficient staff were employed to deliver their family member's package of care.

We discussed the high turnover of staff with the registered manager. They told us staff were recruited for each person's specific package of care. The registered manager used the Provider Information Return (PIR) to tell us that "carers (staff) are subsequently recruited specifically for individual clients and with their full involvement, supported by the family and qualified Independent Living Solutions (ILS) HR officers. The employer of the carers is not ILS but usually the solicitor or client themselves. The employer delegates the employment responsibilities to ILS".

Recruitment procedures ensured staff were suitable to work with vulnerable adults. There were safe recruitment and selection processes in place to protect people. We reviewed staff personnel files and saw

appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Medicine systems were safe. We looked at the medicine systems for the person we visited. Staff maintained a record of medicines received and audits of the systems were maintained. Information leaflets were available giving staff guidance on the medicines prescribed. For example, the purpose of the medicine, storage and side effects. Staff signed medicine administration records (MAR) to indicate medicines administered. Protocols for medicines to be administered (PRN) as required were in place.

Requires Improvement

Is the service effective?

Our findings

The registered manager stated within the Provider Information Return (PIR) that "Individualised client related training is provided for the safe use of specialist equipment and to support client's activities of daily living within or outside their home. Information about safety is highly valued across ILS (Independent Living Solutions). Staff are trained and encouraged to report concerns. Safeguarding training is regularly reviewed and updated and is used to promote learning and improvement. This reflects relevant legislation as well as local arrangements."

The feedback received from staff through questionnaires included "some areas of staff training need to be improved," "some of the training providers are not high quality and lack the appropriate expertise to deliver the training" and "long delay in arranging required training days." 92 per cent of staff that responded through questionnaires told us they had completed an induction which prepared them fully for their role before working unsupervised. 92 per cent also said they had the training needed to enable them to meet people's needs, choices and preferences. However, 85 per cent said they had training in and understand their responsibilities under the Mental Capacity Act (2005).

The registered manager told us they ensured social and healthcare professionals employed by the agency were up to date with their professional qualifications and registrations for their profession. They also told us for new staff they went through the teaching material used for the Care Certificate course. The care certificate covers an identified set of standards which health and social care workers are expected to adhere to. The registered manager said booklets were provided to new staff and induction and training was ongoing. The staff we spoke with said the training they attended was arranged by the relative of the person they were delivering personal care.

One to one meetings with the line manager were undertaken and supported staff with the performance of their roles and responsibilities. The registered manager said one to one meetings were online and that by using this method other staff were able to "tap into staff knowledge and experiences, they were able to post guidance, information and recommendation of services." Also that there were professional mentors for clinical supervision of healthcare professionals. Following from the inspection the registered manager also stated that "one to one meetings are actually undertaken face to face, over the telephone or skype.

The staff we spoke with said one to one supervisions and appraisals were with their line manager. A member of staff commented through questionnaires that "supervisions and support network are the best I have experienced."

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 do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people receiving care in their own home, this is an Order from the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Community professionals employed/used by the agency that responded to questionnaires gave negative feedback regarding staff's understanding of the MCA. 54 per cent said the managers and staff understood their responsibilities under the Mental Capacity Act (2005). Although staff were able to tell us how a person made decisions, they were not aware of the MCA and lacked an understanding of its principles. They said how one person was enabled to make choices such as what to wear. It was stated that this person was shown visual options and would smile or touch the preferred outfit. Where this person disliked the meals prepared they were likely not to eat their meal.

The electronic records for one person said they had cognitive impairments, lacked the ability to problem solve and to understand the consequences of certain actions. These records lacked detail on the specific decisions they could and were unable to make, and who supported them with these decisions such as activities We went to one person's home who lacked capacity to make decisions. Mental capacity assessments were not completed on specific decisions and best interest decisions were not part of the assessment. Their relative said they had lasting power of attorney for finance but it was unclear from records whether this covered their care and welfare. This person was under continuous supervision and staff used bed sides. While DoLS do not apply to people living in their own home, but as the care regime mounts to a deprivation, an application has to be made to the Court of Protection for an order. This meant the registered manager had not contacted the supervisory body to inform them they were caring for a person who was deprived of their liberty.

Plans in managing aggression were in place. The plan in managing aggression for one person lacked insight into the person's cognitive impairments. We saw recorded "there have been a number of violent behaviours and XX was made aware they are not acceptable and if he continues and displays this type of behaviour it is likely he will have to live in an institution where he will no longer have the choices that he currently has." We saw an exchange of email where a member of staff had described the person as "belligerent".

We recommend that the service seek advice and guidance from a reputable source about Mental Capacity Act 2005.

The care plan gave staff guidance on how to enable this person to make informed decisions. For example, staffs were encouraged to advise the person to consider options. They were instructed to advise the case manager for mental capacity assessments where there were concerns about the person's capacity to make decisions.

Management plans instructed members of staff on how to respond during challenging incidents. For example, to keep calm, not to confront the person, the staffs was to draw attention to the person that they were losing their temper as they may not be aware of this and were to remove themselves to a place of safety. Antecedents, Behaviour and Consequences (ABC) were used to analyse behaviours to then develop care plans on how staff were to respond to identified triggers. The ABC charts included a description of the behaviour.

Some people were supported with menu planning. We visited one person and the staff on duty said the team delivering personal care discussed menu planning. They said all meals were prepared and a record of food served was maintained. They said alternatives were served when the person refused the meals served.

We observed the lunchtime meal which the person ate without support from staff.

The people that responded through questionnaires agreed that their carers had the skills and knowledge to give them the care and support needed which helped them to be independent.

Good

Is the service caring?

Our findings

People that responded to questionnaires agreed they were introduced to their care and support workers before they delivered personal care. They also confirmed their care and support workers always "treat me" with respect and dignity and that they were caring and kind. The community professionals employed/used by the agency said the staff they met were kind and caring towards the people who use the care agency.

We visited one person at their home and observed the interaction staff had with the person. Two staff were present during our visit and we saw good interaction with the person. The person's preference was to move around on the floor and staff sat with the person. We saw objects of interest were used to interact with the person. The relative of the person we visited said the staff were caring. They said they were kept informed about outcome of appointments and important events.

The registered manager told us in the Provider Information Return (PIR) that "our service is person centred, we work together towards the same goal, to support our clients to maximise their recovery, potential and their independence at their own pace. We aim to involve clients in everything we do. Each client and their family is actively involved in the assessment, which looks at their pre accident lifestyle or birth injury and the impact this has had on them. As highly skilled health or social care professionals with extensive experience working with individuals with disabilities they use the experience gained in order to support individuals to navigate their road to recovery in the most effective manner. Client's priorities are highlighted in the assessment recommendations, we recognise that meeting a need that is of particular importance to the individual makes a huge difference to their recovery even if that need does not have clinical relevance to their situation in terms of evidence based practice. We ensure that clients are cared for in the way that they would wish through the provision of effective recruiting with support from a qualified HR team or if more appropriate, support workers are sourced through an agency. All support workers are inducted by the Case Manager (or team leader if appropriate)."

The views of people using the agency were gained using surveys. The registered manager said 140 questionnaires were sent and 12 responses were received from people who received personal care from the agency. These people were satisfied with the level of care received from the staff.

The members of staff we spoke with were able to identify the person's signs of likes, dislikes and preferences. They said a person who was unable to speak and made vocal noises to indicate to staff their preferences. For example, the person made vocal sounds to indicate the preference on the staff to deliver personal care. A member of staff said when the person needed time on their own in their bedroom they made vocal noises until staff left their bedroom. They also said that during the day when the person wanted time alone the person moved away from them.

Good

Is the service responsive?

Our findings

The people who responded to questionnaires said they were involved in decision-making about their care and support needs. Community professionals employed/used by the agency said the staff acted on any instructions and advice given. The relative we spoke with said they were invited to reviews meetings to discuss their family member's care needs.

Electronic records were kept at the agency office with copies held at the person's home. People's background was gathered and initial assessments were conducted to assess areas of need and included religious needs. The thumbnail sketch provided an overview of the person which included the associated risks to the needs identified, the prescribed medicines and family dynamics.

Care management plans included the delivery of care. For example, for one person the delivery of care was for staff to speak clearly, to avoid "arguing" and to use simple language and avoid "abstract use of language."

The electronic personal care plan for this person stated they were independent with their hygiene routines but needed prompting to undertake some routines with some support with washing their hair. The movement section stated the "neuro physiotherapist" adviced and gave staff guidance to support the person with daily exercises. The nutrition care plan described the person's ability to prepare their meals and the assistance needed from staff with food preparation.

Care plans were not always reviewed when people's needs or circumstances changed. The care plan kept in one person's home was dated 2012 and was signed as updated annually. However, the person had moved house and there was new staff working with the person. The care plan had some background information and although the routines of the person were included the action plans lacked details for example, the action plan stated "needs full assistance" But did not explain exactly what this meant

The electronic care plan for unacceptable behaviours detailed the behaviours the person at times may display. The delivery of care section of the care plan gave staff guidance on how to respond when these behaviours were presented. For example, members of staff were to remain calm, they were to remove themselves from the situation and to report the incident to the case manager or to the Police if appropriate. Staff were also directed to document incidents of this nature.

Electronic care plans to support one person with activities was in place. The healthcare professionals were involved with the supporting the person and supported them to choose the equipment needed for the chosen activity. The staff we spoke with told us they organised activities such as visits to restaurants.

People responding to questionnaires said their care and support workers respond well to any complaints or concerns raised as well as the staff at agency office. The registered manager told us there was one formal complaint which was being investigated. Members of staff told us through questionnaires that managers were accessible and approachable and dealt effectively with any concerns raised. The relative we spoke

with during a visit said they had not approached the office staff at the agency with concerns. They said a complaints procedure was not provided.

Good

Is the service well-led?

Our findings

Quality assurance systems were in place and although clinical audits strategies were identified as an area for improving, action plans were not in place on how the delivery of care was to be assessed and on how it was to improve. Some staff and community professionals employed/used by the agency that responded to questionnaires indicated there were areas for development. These areas included the quality of training and the staff's understanding of the Mental Capacity Act 2005.

People who used the agency, staff and community professional employed/used by the agency said their views about the service were not sought. People responding to questionnaires told us they knew who to contact at the agency office and the information they received was easy to understand. While relatives told us their feedback on the agency was sought, 33 per cent of people giving feedback through questionnaires disagreed that the care agency had asked them for their feedback about the agency. The agency sought feedback from the people who used the agency and the registered manager told us 140 questionnaires were sent and 12 responses were received. Five people made comments about the personal care received and the registered manager responded individually to these individuals.

A cascading system for staff to receive feedback from managers was in place. The registered manager told us team meetings with professional mentors were organised and any agreements reached, policy changes and information shared was cascaded to case manager by their mentors. It was an expectation that case managers then passed the information onto staff within their line management responsibility. The registered manager said twice yearly formal meetings were arranged to look at all cases to ensure all working files have been reviewed. At the most recent meeting the registered manager said there were no gaps in the quality of care files and mandatory training had been discussed. The email confirming the meeting provided an overview of topics discussed. For example, refresher safeguarding vulnerable adults training and access to moving and handling training. Following the inspection the registered manager told us "the operations team have monthly skype calls with the professional mentors to cascade information to case managers and if appropriate carers. These meeting are followed up with an email confirming the content of the meeting and any actions."

Staff reported accidents and incidents to senior managers at the agency office. The registered manager said the reports were individually analysed and passed onto case managers and care plans updated as appropriate. The registered manager told us the member of staff involved discussed accidents and incidents with the case manager.

The statement of purpose for this service included a mission statement, the aims and objectives and the services and facilities the agency provides. Aims and objectives included the delivery of person centred care, to have a committed and competent workforce and to work in partnership and make positive contributions to the community.

Comments from staff responding to questionnaires demonstrated that these visions and values were put into practice. Responses from staff included "the client is always put at the centre of the care package and

increasing her independence and self-confidence is always at the forefront of the managers." The comments from community healthcare professional employed by the agency and responding to questionnaires included, "there is good communication from management down to therapists and vice versa. As a clinician and the clinical lead I am always listened too and my views are considered and where appropriate acted upon. Independent Living Solutions (ILS) provides a proactive service for their clients and seeks to continually review and improve services so that the best standard of care can be provided," and "I have enjoyed working with the staff at ILS and find them very approachable and easy to contact to discuss my client's needs". However, this was not consistent with our findings. A relative who responded to the questionnaire stated "the service is excellent but I consider it to be very expensive".