

St Anne's Community Services

St Anne's Bradford

Supported Living Services

Inspection report

Oakwood Court
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Bradford
West Yorkshire
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09 March 2016

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection was announced, the provider was given 24 hours' notice. At the time of the inspection the service was supporting 32 people with personal care.

The last inspection took place in December 2013 and the provider was compliant with all the standards inspected.

St Anne's Bradford Supported Living Services is a domiciliary care service. The service supports adults with learning disabilities to live in their own home. In addition, through a floating outreach service they support adults with learning disabilities, head injuries and /or mental health issues with individual packages of care ranging from a small number of hours per day or per week through to 24/7 depending on the individuals assessed needs.

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

People told us they felt safe and could speak to any of the staff if they were worried about anything. The manager understood their responsibilities for safeguarding people and staff were trained to understand and recognise abuse. They knew who to report concerns about people's safety and welfare within the organisation and to external agencies if necessary.

Sufficient numbers of staff were deployed to provide people with the care and support they needed. The required checks were done before new staff started work and this helped to keep people safe. Staff were provided with training and support to help them carry out their roles. However, some staff felt the training was somewhat limited.

Where people were supported with their medicines this was done safely. There were safe systems in place to support people with managing their finances.

Risks to people's safety and welfare were identified and managed. Risk assessments clearly identified the risks to people and what could be done to mitigate the risks and keep them safe whilst promoting independence. Staff were provided with information about how to deal with emergencies and senior managers were on call outside of office hours to provide support.

Meals at the supported living houses were prepared and cooked by staff with the involvement of the people who lived there. We saw people's nutritional needs and preferences were taken into account.

We found the service was working in accordance with the Mental Capacity Act 2005 and this helped to make

sure people's rights were protected. When there was any doubt about a person's capacity to understand a particular decision the correct process was followed to make sure any actions taken were in their best interests.

'Health Action Plans' were in place to help support people to lead a healthy lifestyle. These included information about health care professionals involved in supporting people and details of how people were able to communicate health care issues and emotions. The service worked with other health and social care professionals to help achieve positive outcomes for people.

To promote person centred care the provider was in the process of training all staff on Positive Behaviour Support (PBS). This is a care model promoted by BILD (British Institute of Learning Disabilities) as the preferred approach when working with people with learning disabilities who exhibit behaviours described as challenging.

People told us staff respected their privacy and dignity and provided them with the support they needed. Staff demonstrated a caring attitude and we saw the interactions between staff and people who used the service were friendly and warm. People were supported to maintain relationships with family and friends and take part in a range of social activities of their choosing.

People were involved in decisions about all aspects of their care and support and where appropriate people were supported to access advocacy services.

The care documentation supported a person centred approach. However, we found this was not always reflected in the way they were completed and we found the records were not always up to date. We also found the records in the office did not always have the same information as the records in people's houses.

There was a complaints procedure. The people we spoke with said they had no reason to complain but would not hesitate to speak with one of the staff or the manager if they had any concerns.

There were systems in place to monitor and improve the quality and safety of the services provided.

The way the service was organised prevented the registered manager from fulfilling their role and responsibilities. The service was divided into four operational patches and they had limited access to the records about people who used the service and staff in three of the four patches. In addition, they did not have line management responsibility or authority over the other patch managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff were trained to recognise and report abuse. The required checks were done before new staff started work. This helped to protect people from the risk of abuse.

There were enough staff to provide people with appropriate care and support.

People's medicines were managed safely.

Risks to people's safety and welfare were identified and managed.

Is the service effective?

Good ●

The service was effective.

People's rights were protected and they were supported to make choices by staff who had a good understanding of the principles of the Mental Capacity Act 2005.

People were supported to have a choice of food and drink which took account of their preferences.

Staff were supported to deliver safe and appropriate care.

Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect and their rights were promoted and protected.

People were supported to maintain relationships with family and friends.

People were supported to be actively involved in decisions about all aspects of their support and care. People were supported to access advocacy services where appropriate.

Is the service responsive?

The service was not consistently responsive.

The care documentation supported a person centred approach however we found peoples care records were not always completed in a person centred way and were not always up to date.

People were supported to take part in a variety of social, leisure and educational activities which took account of their preferences.

Information about the complaints procedure was made available to people in a easy read format.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

The registered manager was positive and enthusiastic about their role and committed to providing the best service they could for people. However, they were limited in what they could do because of the way the service was set up.

The provider had systems in place to monitor and improve the quality and safety of the services provided.

Requires Improvement 

St Anne's Bradford Supported Living Services

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 09 March 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection was carried out by two inspectors.

We visited the office at Oakwood Court and visited one of the houses where people who used the service lived. We spoke with the registered manager, a senior support worker and three support workers. We looked at three people's care records, medication records, four staff files, training records, duty rotas and other records related to the management of the service such as meeting notes and quality assurance records. We spoke with two people who used the service in their home and spoke with another person by telephone. We spoke with a health care professional who had recently worked with the service.

We asked the provider to complete a Provider Information Return (PIR) which was returned to us in a timely manner. 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 reviewed all information we held about the provider and contacted the local authority to ask for their views on the service.

Is the service safe?

Our findings

People told us they felt safe and could speak to any of the staff if they were worried about anything.

The provider had policies and procedures in place to help make sure people were protected from abuse. In the Provider Information Return, (PIR), the registered manager told us staff in the service attended safeguarding training and this was reinforced through team meetings and team briefs. They said all staff were aware of and had access to the Whistle Blowing policy and took part in safeguarding quizzes. Staff had been provided with pocket sized safeguarding booklets which included the relevant contact details. People who used the service had access to easy read safeguarding materials where applicable

In people's care records we saw care plans relating to keeping safe were in place. Each care plan included the telephone numbers for the local safeguarding team.

The staff we spoke with demonstrated a good understanding of abuse and were aware of how to report any concerns about people's safety and well-being. They told us they did not have concerns about the safety of people who used the service and said they would recommend the service.

The registered manager had a good understanding of their responsibilities in relation to safeguarding and our records showed they had made appropriate referrals in response to safeguarding concerns.

The registered manager told us that staffing was arranged around people's dedicated care hours and any 'core' hours. Core hours were times staff spent in the multi-occupancy houses where staff were available to all of the people living there. The registered manager said that included night times. We asked how staffing would be maintained during the night if, for example, a service user became ill or needed to be escorted to hospital. They told us there was always back up including themselves if the need arose.

The registered manager explained they were supported with the recruitment of new staff by the providers Human Resources, (HR), department which was based in Leeds. There was a clear recruitment procedure in place; applicants completed an on-line application form and this information was used to select a short list of candidates to be interviewed. Interviews were carried out by two people, one of whom was a first line manager. Successful candidates were then required to provide two references and complete a criminal records check with the DBS (Disclosure and Barring Service) before they were offered a position. All new staff had a six month probationary period before their employment was confirmed. This helped to protect people from the risk of being supported by staff who were not suitable to work with vulnerable adults. We looked at four staff recruitment files, two of the four files contained a pro forma from the providers HR department which confirmed all the required checks had been completed and were satisfactory. This was discussed with the registered manager who confirmed they had received confirmation that the checks had been completed. They said the absence of the pro forma in two of the files was an oversight and said they would address it immediately.

We looked at care records for three people. For two of these people we looked at the records kept in the

office as well as those in the person's home. For one person we looked only at the records kept at the office.

We saw each care file included a number of support plans. At the bottom of each support plan page was a box for staff to complete to indicate if there was a risk assessment attached to the particular area of need. The care records we looked at in the office did not include the risk assessments. However, the care records we saw in the people's homes did. We saw risk assessments had been developed in a number of areas relating to the person's activities, behaviours and particular vulnerabilities. For example one person had risk assessments in place covering cooking, self-neglect, aggression and exploitation. The risk assessments clearly identified the risks to the person and what could be done to mitigate the risks and keep the person safe whilst promoting independence.

The registered manager told us each tenancy had a service file which included details of how to deal with emergencies. For example, if people needed medical help outside of normal surgery hours the first point of contact was the NHS 111 service. In addition, there was an emergency on call service provided by area managers.

The provider had policies and procedures in place to help make sure people's medicines were managed safely. The registered manager told us all staff involved in supporting people with their medicines received training both in house and from the supplying pharmacy. In addition, they said all staff completed medication competency assessments when they started work and following any medication errors.

We looked at how medicines were managed in one of the supported living houses. We saw medicines were stored safely and each person had medication administration records (MAR's). We saw the MAR's clearly identified the medication to be given, how it should be given and at what time. Staff had highlighted the times of administration for extra clarity. We saw the MAR's had been completed appropriately. None of the medicines we looked at were prescribed on an 'as required' or PRN basis. Staff told us they supported people to order their prescriptions ensuring medicines did not run out. We saw the 'Health Action Plans' in people's care files included a section relating to the medicines the person took. This section had not been completed in one of the files we looked at.

In the PIR the registered manager told us the management team carried out weekly checks on all service users' finances. During the inspection we saw a safe system was in place for supporting people to manage their finances. Money and bank cards kept for the person in the supported living house was kept in a 'Versapak'. This is a pouch which is sealed with a numbered seal each time it is opened. Every time the seal had been broken a record was made in the person's financial record with details of the money put in or spent or what the bank card had been used for. The number of the new seal was then recorded. We saw the seal on one person's Versapak corresponded with their financial record.

Is the service effective?

Our findings

The registered manager told us all new staff received induction training and this was confirmed by the records and the staff we spoke with. The registered manager told us all new staff were required to complete the Care Certificate training unless they had a relevant qualification such as an National Vocational Qualification at Level 2 or above. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.

There was a training matrix which showed the training staff were required to complete, mandatory training, and other training which was related to the needs of people who used the service. The mandatory training included safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards, emergency aid, equality and diversity, moving and handling, fire safety, food hygiene, health and safety and infection control. The service specific training covered topics such as autism, diet and nutrition, epilepsy, dementia, dignity and respect and diabetes. The records showed staff were up to date with mandatory training however the service specific training was inconsistent. For example, only five staff had completed training on epilepsy and diet and nutrition and while the majority of staff had completed training on autism many had not had an update since 2012 or 2013.

This was consistent with comments made by some of the staff who said that although they received training they felt it was limited. However, they also said they felt supported by the service. Staff support was provided by way of regular one to one supervisions, annual appraisals and team meetings.

The registered manager told us the provider had made training on Positive Behaviour Support (PBS) mandatory in September 2015 and this was now being rolled out across the organisation. PBS is a person centred model of care promoted by BILD (British Institute of Learning Disabilities) as the preferred approach when working with people with learning disabilities who exhibit behaviours described as challenging. The provider is an accredited by BILD to provide this training.

Meals at the supported living house we visited were prepared and cooked by staff with the involvement of the people who lived at the home. One person told us how much they enjoyed cooking but accepted they needed support to remain safe when doing so. We saw they were involved in the preparation of the evening meal. People's care files and health action plans included details of their nutritional needs. One person's care plan detailed clearly their very specific likes and dislikes in relation to their food and drink.

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 to receive care and treatment when this is in their best interests

and legally authorised under the MCA. In domiciliary care services applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA and whether any applications had been made to the Court of Protection and if so whether the provider was complying with any Court Order

The registered manager told us none of the people who used the service had a Court Order in place. They had a good understanding of the principles of the MCA. They gave us examples of how people had been supported using the best interests decision making process when there had been any doubt about their capacity to make complex decisions about their care and treatment.

Staff we spoke with had a good understanding of the principles of the Mental Capacity Act 2005 and told us how they supported people to make choices about the support they received.

People's care files included a 'Health Care Action Plan' which contained a list of health care professionals involved in supporting the person. The Health Care Action Plan also included details of how the person would be able to communicate health care issues and emotions and how they could be supported to lead a healthy lifestyle.

We spoke with one health care professional who had recently worked with the service supporting one individual. They told us they would recommend the service and said the staff and management delivered care and support in a person centred way. They said the service had worked well with other members of the multi-disciplinary team to achieve a positive outcome for the person who used the service.

Is the service caring?

Our findings

One person we spoke with told us staff gave them all the support they needed. They said they liked the staff. We asked if staff respected their privacy and made sure they did not feel embarrassed when supporting them with their personal care needs. The person said staff knocked on their bedroom door and waited for them to answer before they came in and said they "never felt awkward or embarrassed" when staff were supporting them. Another person said, "They are good, they help us."

Staff we spoke with demonstrated a caring attitude and we saw the interactions between staff and people who used the service were friendly and warm. Staff demonstrated a good knowledge of the people they supported and spoke of their wish to develop a more person centred approach.

Staff received two yearly updates on Equality and Diversity training to help make sure they had the knowledge and skills to promote and protect the human rights of people who used the service. The staff we spoke with demonstrated a good understanding of their role in promoting and protecting people's rights.

The registered manager explained how the service supported people to maintain relationships with family and friends. For example, one person had to move out of their home due to a change in circumstances leaving their friend alone there. Staff arranged social activities such as meals out and church visits so that they could continue to meet and maintain their relationship.

The service arranged regular tenants meetings in the homes for people who wanted to participate. This gave people the opportunity to talk about what they had done, where they had been, who they had met, their achievements and anything they would like to change about their lives. During the meetings people were asked if they felt they were being treated with dignity and respect and if they were happy with the way their care and support was being provided. The registered manager told us the feedback from these meetings had been very helpful in giving them an insight into how people who used the service felt about their care and support.

The provider arranged review meetings for people who used the service. The registered manager told us they sent out invitations and where people had capacity they were involved people in all aspects of their support plan.

The registered manager told us when people did not have capacity or there was a concern about their capacity to make a particular decision, best interests decisions were made within a multi-disciplinary team setting. Where appropriate, people who used the service were supported to access advocacy services.

In the PIR the registered manager told us St. Anne's mission statement is 'To support individuals to achieve their aspirations by providing services that promote dignity, independence, opportunity and inclusion'. To apply this to their day to day work the service had an advocacy group where people who use the service and staff discussed topics such as safeguarding, dignity and respect and safety. The group had also discussed different opportunities for people using the service in Bradford to take part in chosen activities or day trips.

For example, last year a group of people had chosen to have a day trip to Blackpool and this had taken place with support from staff.

Is the service responsive?

Our findings

The care documentation supported a person centred approach. Each care file included a document titled 'My support plan' and included details about the person, their lifestyle, family and education. It also included a section for the person to say what good and bad things had happened in their lives. This information is important in helping staff understand the person, particularly those for whom verbal communication is difficult. The completion of these documents varied within the three files we looked at. For example, in one person's records the names of their family were listed but there was no information about who they were, what the person's relationship with them was like or whether they were involved in their life. We also noted that the 'My key contacts' page still included the name of a member of staff who no longer worked at the service.

Care records also included a 'My timetable' so that the person and their support worker could plan the weeks activities and make sure arrangements are in place for attending college or other centres. One of the timetables we saw was out of date as it referred to the person attending college. The person and staff said they no longer did this.

Support plans had been developed with a person centred approach. For example headings included 'How I communicate, Maintaining my dignity, My personal hygiene and Understanding my behaviours and emotional needs.' However, the completion of the support plans had not always been done with a person centred approach talking more about the person rather than demonstrating their inclusion and consent during the support planning stage. Daily records were written by staff about the person rather than demonstrating the person had been consulted about their day or supported to write their own daily records. Staff we spoke with said they would welcome working with a more person centred approach.

Support plans were good and gave staff the information they needed to support the person appropriately and in the way they preferred. For example the support plan for managing one person's anxiety gave sufficient detail to make sure staff were consistent in their support. The support plan included guidelines for managing anxiety from the Psychological Therapies Service. This showed that health care professionals were involved in the care and support of people using the service. Another person's support plan said they only wanted female staff to support them when taking a bath.

We saw people had a VIP passport within their care records. This is a document people can take with them if they need to be admitted to hospital to give hospital staff information about the person and their support needs.

We saw people's Health Care Action Plans had not always been fully completed and some of the information included was not correct. For example, one person was recorded as having no problems with sight when they wore glasses and would therefore need regular optician appointments. In another person's plan we saw they had set a goal of swimming and walking to promote a healthy lifestyle. However, this had not been reviewed on the set date of October 2015 and the person and staff told us that although they did do a lot of walking they had not been swimming for some time. The registered manager provided an

explanation as to why the person had not been able to go swimming recently.

We saw one of the three Health Care Action plans we looked at had been signed by the person.

We saw people were supported to follow activities and pastimes of their choice and these were recorded within the support plans. Some people were supported to attend college or day centres for educational or social activities. Staff in the supported living house we visited knew what people's interests were and how they liked to spend their time. We saw from records how one person was being supported to achieve their goal of going to London for a short break.

We asked two people what they would do if they were unhappy about something. They said there wasn't anything but knew they could speak to the staff if they needed to.

The provider had a complaints procedure which included an easy read version for people who used the service. The registered manager told us they had received three compliments and two complaints in the 12 months prior to the inspection. They explained the actions they had taken to deal with the complaints, these included putting risk assessments in place and liaising with external agencies such as the Bradford hate crime alliance.

Is the service well-led?

Our findings

The registered manager explained the service was divided into four patches. Each patch had a first line manager and at least one senior support worker, one of the larger patches had two senior support workers. The registered manager was responsible for one of the four patches but did not have line management responsibility or authority for the other three patches. The registered manager told us the provider had set up domiciliary care meetings so that the other three first line managers could share information with them. However, this did not alter the fact that the registered manager was being held to account for areas of work over which they had no day to day control.

In addition, we found the registered manager had only limited access to electronic records for service users and staff in the three patches for which they did not have day to day operational responsibilities. They told us the area manager was able to access all the records but the area manager was not based at the service and their role meant they covered a large geographical area.

The provider is an organisation and one of the conditions of registration is that the regulated activity is managed by a registered manager. The limitations imposed on the registered manager by the organisational structure meant they could not effectively manage the regulated activity across the whole service and therefore the provider was at risk of breaching one of their conditions of registration.

In the PIR the registered manager told us the area manager carried out monthly audits covering the topics such as service users money, infection control, the Mental Capacity Act, staff training & supervision, environmental health and safety, nutrition and diet, service user activities and holidays, administration/communication books, household monies, support plans and risk assessments, assessments, safeguarding, medication, fire records, information governance and vehicle checks. These checks were rated as compliant or non-compliant. The audits were then forwarded to the regional operations manager for comments and the registered manager was responsible for implementing any actions required.

The registered manager told us weekly and monthly audits and random spot checks were carried out in the tenancies, (homes occupied by service users). However, when we visited one of the homes we found there was little detail of what the audit had looked at and on most occasions the staff member had just recorded 'audit done'.

The registered manager told us they operated an open door policy at the office for staff and people who used the service. On the day of the inspection we found the office was busy with staff coming and going and the atmosphere was friendly and welcoming.

Open communication was promoted by a variety of methods including regular staff meetings, staff supervisions, communication books, diaries and posters on topics such as safeguarding and whistle blowing.

People who used the service and other stakeholders were sent annual satisfaction surveys. The registered manager was responsible for implementing any changes identified to improve the service.

Accident and incidents were reported to the first line managers initially. They were monitored by the area manager to make sure appropriate action had been taken to deal with the accident and/or incident and to reduce the risk of recurrence. We checked to see if appropriate actions had been taken in response to a number of incidents which the Commission had been notified about and found they had.

The provider had a number of external quality awards which included Investors in People – Gold, Mindful Employer and Stonewall Diversity Champions.