Aspire Healthcare Limited

Aspire Supported Living

Inspection report

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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

This was an announced inspection carried out on 4, 5 and 7October 2018.

This was the first inspection of the service since it had re-registered with the Care Quality Commission in July 2017 because of changing its location.

Aspire Supported Living Service provides personal care and support to 16 people with learning disabilities, autism or associated related conditions and/or mental health needs. Some people may have behaviours that challenge. People live in 11 supported living settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using Aspire Supported Living receives regulated activity; CQC only inspects the service being received by people provided with personal care, help with tasks related to personal hygiene and eating. Where they, do we also take into account any wider social care provided.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in place who was also the provider. 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 service had a quality assurance programme to check the quality of care provided. However, the audits had not identified areas of improvement identified at inspection.

Staff knew people's care and support requirements. However, some improvements were required to record keeping to ensure that they accurately reflected people's care and support needs. People's records did not all correspond with the current service provider with new records being introduced when a person started to use the service.

Risk assessments were in place and they identified some of the risks to the person as well as ways for staff to minimise or appropriately manage those risks. Systems were in place for people to receive their medicines in a safe way.

People said they were safe using the service. Staff had received training with regard to safeguarding adults

and said they would report any concerns to the service or people's care managers. There were enough staff available to provide safe care to people. We have made a recommendation about establishing arrangements for staff cover when regular staff are not available.

There were some opportunities for staff to receive training to meet people's care needs. A system was in place for staff to receive supervision and appraisal and there were appropriate recruitment processes being used when staff were employed. We have made recommendations about staff recruitment and staff training.

People were supported to have maximum control over their lives and staff supported them in the least restrictive way possible; policies and procedures supported this practice. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People were encouraged to maintain a healthy diet.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had access to an advocate if required.

People were provided with opportunities to follow their interests and hobbies. People were encouraged and supported to go out in the local community and maintain relationships that were important to them.

Communication was effective to ensure staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse and staff had received training with regard to safeguarding. Staffing levels were sufficient to meet people's needs safely and appropriate checks were carried out before staff began work with people.

Systems were in place for people to receive their medicines in a safe way.

Positive risk taking was encouraged as people were supported to take acceptable risks to help promote their independence.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and support.

People's rights were protected and there was evidence of best interest decision making. This was required when decisions were made on behalf of people when they were unable to give consent to their care and treatment.

People were supported to eat and drink according to their plan of care. Staff liaised with General Practitioners and other health care professionals to make sure people's care and treatment needs were met.

Is the service caring?

Good

The service was caring.

People were encouraged to express their views and make decisions about their care. People were supported to maintain contact with their friends and relatives. Staff supported people to access an advocate if required.

People's privacy and dignity were respected and their independence was promoted.

People told us staff were kind and caring and they were complimentary about the care and support staff provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records did not all reflect the care provided by staff. Staff were knowledgeable about people's needs and wishes.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to and expressed confidence in the process.

People were supported to be part of the community and to follow their hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager and management team monitored the quality of the service provided and introduced improvements. However, they had not identified issues we found at inspection.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

People told us the management team were approachable. They had the opportunity to give comments about the service the received.

Aspire Supported Living

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 4, 5 and 7 October 2018 and was announced. We gave the provider 24 hours' notice to ensure someone would be available at the office. We carried out a site visit on the first day of inspection, on day two we visited three people's houses and on day three we carried out telephone interviews with staff.

The inspection was carried out by one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care.

On the first day of inspection we spoke with the registered manager and two service managers. We reviewed a range of records about people's care and how the service was managed. We looked at care records for five people, recruitment, training and induction records for five staff, staffing rosters, staff meeting minutes and quality assurance audits the registered manager had completed. After our visit to the office we visited three people in their own homes and spoke with two support workers and a service manager. We telephoned and spoke with four support staff on day three of the inspection.

Good

Is the service safe?

Our findings

People told us they were safe with staff support. One person told us, "I do feel safe with the staff. Another person said, "I feel safe living here." A third person commented, "I feel safe. We have staff here 24/7." A staff member told us, "I do feel safe working for the service." Another staff member said, "I certainly feel safe."

Most people and staff were kept safe because suitable arrangements for identifying and managing risk were in place. Risk assessments were in place that highlighted any areas of risk to people's safety and wellbeing. In areas such as distressed behaviours or choking. However, a risk assessment was not in place for the management of epilepsy or where a person may be at risk of self-harm. We discussed this with the registered manager and received evidence after the inspection that the documents had been put in place immediately. Other risk assessments showed that where a risk was identified, there was guidance included in people's care plans to help staff support them in a safe manner. Risk assessments were also used to promote positive risk taking and support individual lifestyle choices, such as going out independently and medicines management.

A personal emergency evacuation plan (PEEP) was available for each person. The plan was reviewed regularly to ensure it was up-to-date if the person needed to be evacuated from their home in an emergency.

Detailed behaviour management support plans were in place for people who displayed distressed behaviour and they were regularly up-dated to ensure they provided accurate information. Support plans contained information to show staff what might trigger the distressed behaviour and what staff could do to support the person. They provided guidance for staff to give consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed. One staff member told us, "I have received break-away training about physical restraint but I have never had to use it." Another staff member said, "I have done distressed behaviour training."

Staff were clear about the procedures they would follow should they suspect abuse. They expressed confidence that the management team would respond to and address any concerns appropriately. Staff had received training in relation to safeguarding. Staff understood the need to protect people who were potentially vulnerable and report any concerns to managers or the local authority safeguarding adults team. One staff member told us, "I completed safeguarding training."

A safeguarding log was in place that documented any safeguarding incidents and action that was taken but it did not include that the safeguarding team had been notified, who was investigating the incident where required and the outcome of the safeguarding. We discussed this with the registered manager who told us it would be addressed.

There were sufficient numbers of staff available to keep people safe. However, some staff did say they were called upon to work extra hours, even though they had been on duty for three days. This sometimes happened when staff were sick or unavailable to work. Staffing levels were determined by the number of

people using the service and their needs. Staffing levels could be adjusted according to the needs of people and we told that the number of staff supporting a person could be increased or decreased as required after negotiation with commissioners of the service. One person said, "Staff will support me when I need help." Staff usually worked on a one-to-one basis with some people they supported during the day and overnight.

The staffing rosters showed that people were supported by the same member of staff for a continuous period where they worked on their own and slept on the premises and provided support during the day for three days without other staff. Some staff told us if a member of staff called in sick it meant the member of staff was unable to go off duty after spending 72 continuous hours on the premises as no other members of regular staff may be available to relieve them.

We recommend that arrangements are put in place to ensure that additional support workers are available to provide support when regular staff are not available due to holidays or sickness.

People and staff had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. One staff member commented, "There is always a senior available for advice at the end of the telephone." Another staff member said, "The telephone is always answered if you call out-of-hours."

Analysis of any incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Reflective practice took place with staff after any individual behaviour management incident to review if anything could have prevented a situation from occurring or sometimes escalating.

Staff confirmed they had the equipment they needed to do their job safely. They were provided with protective clothing, having access to gloves and aprons. They had completed training in infection control.

People received their medicines when they needed them. Staff had completed medicines training and periodic competency checks were carried out. One support worker told us, "I am observed every year as I give out medicines." Staff had access to a set of policies and procedures to guide their practice. Medicines were obtained on an individual basis, with some people managing these with the support of staff. The management team also undertook periodic audits, and any shortfalls were identified and suitable actions put in place.

Staff personnel files showed that staff were appropriately recruited to ensure suitable people were employed. Interview notes showed that sometimes only one staff member interviewed prospective staff members. We discussed with the registered manager that at least two members of staff should be involved in face-to-face interviews to ensure a fair process was followed. They told us that this would be addressed.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. A staff member commented, "We get lots of training." Another staff member told us, "I have just completed a National Vocational Qualification at level two", now known as the diploma in health and social care. A third staff member said, "We do e-learning training. It is not the same as face-to-face training when you could ask questions during the training" and, "We have 14 courses to complete on e-learning."

The staff training records showed staff were kept up-to-date with safe working practices and they had opportunities for other training to understand people's care and support needs. Staff training courses included mental capacity and deprivation of liberty safeguards, dementia awareness, distressed behaviours, person-centred care, mental health and drug and alcohol. Staff told us and the staff training matrix showed all training was provided by e-learning. This meant staff did not receive face-to-face training for courses with a practical element such as for fire training and moving and assisting.

We recommend that staff receive a mixture of e-learning and face-to-face training to ensure their understanding and competence.

Staff told us when they began working at the service they completed an induction and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member commented, "I worked with other staff and shadowed them during my induction." Another staff member said, "We are not thrown in at the deep-end working on your own, staff and management are available to ask things." Staff told us induction included information about the agency and training for their role. They were issued with an employee handbook and key policies and procedures to make them familiar with the standards expected of them.

Staff were supported with regular supervisions and appraisals. They told us they received supervision from the management team, to discuss their work performance and training needs. One staff member told us, "I have supervision every two or three months." Another member of staff said, "I get regular supervision from the service manager."

Staff told us there was good communication and that they worked well together in providing people's care. One staff member commented, "We have a handover when we come on duty." Another staff member said, "There is a communication book and diary to keep us up-to-date." A third staff member told us, "Communication is improving between seniors and support workers. This helps with people's anxieties when they don't like change" and, "Handover makes clear if there are any issues and if any appointments are due."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

People were supported to access community health services to have their healthcare needs met. One person commented, "I would tell staff if I was feeling unwell." People's care records showed they had input from different health professionals. For example, the GP, psychiatrist, mental health nursing service, psychologist and speech and language therapist.

People were provided with different levels of support to meet their nutritional needs. This ranged from help with food shopping, support in making choices about menus and preparing meals to assisting people with eating. People's care records included nutrition information and these identified requirements such as the need for a weight reducing or modified diet. Where anyone was at risk of weight loss, their weight was monitored more frequently as well as their food and fluid intake. One person told us, "I have lost over a stone in weight with cutting down on some foods." Another person told us, "I love food. I make a shopping list before I go shopping with staff."

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.

The service worked within the principles of the MCA and trained staff to understand the implications for their practice. Consent was obtained from people in relation to different aspects of their care. Mental capacity assessments had been carried out, that included an assessment of people's understanding and agreed restrictions were in place to manage their previous behaviours. Records showed the decision making involved relevant professionals as well as the person and their family or representative.

Good

Is the service caring?

Our findings

People we spoke with told us they were very happy with the support and the staff who cared for them. One person commented, "I am settling in well here." And, "I love living here. The staff support me if I need it." Another person said, "Staff are kind and respectful." Other people's comments included, "It is a Godsend living here, I know where I am", "Staff look after me", "I have much more freedom" and "I am listened to by staff."

Positive, caring relationships had been developed with people. Staff interacted with people in a kind, pleasant and friendly manner. Staff understood their role as an enabler to support people to learn skills and to be involved in all aspects of daily decision making.

There was a stable staff team with some staff having worked with the same people in a different setting for several years. Staff were given training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support, if the person consented to sharing their information. Staff supported people to keep in touch with relatives by telephone or supporting them to visit. One person told us, "I am going to visit my Mum this weekend." Another person commented, "My family visit me."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. People's care records contained information about people's likes, dislikes and preferred routines as well as their dreams and aspirations. Examples in care records included, "No spicy food. May like a fry up now and again", "[Name] likes gardening, visiting Tynemouth market" and "[Name] likes to place a bet at the bookies."

People were encouraged to make choices about their day-to-day lives. They told us they could decide, for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. One person told us, "I go to my room at 11pm." And, "They [staff] can't make me do things but they can advise me." Another person said, "I like to go to bed early." Other people's comments included, "I will tell staff what I want to eat", "I choose my own clothes each day", "I like watching quiz programmes" and "I chose the furniture and things in my house."

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. Advocates can represent the views of people who are not able to express their wishes, or have no family involvement. The registered manager told us a formal advocacy service was available and was used for some people.

Requires Improvement

Is the service responsive?

Our findings

Some people had previously received residential care from the provider before they moved to the supported living scheme where they had become tenants of their own home. Records showed the previous records had transitioned with the person, which was good practice. However, they were difficult to follow as a new record documenting the person's care and support needs had not been created when the person had moved to the service. Therefore, records contained a range of historical and current information which did not all show they reflected people's current support needs.

Records showed pre-admission information had been provided for people who were to use the service.

Support plans for most care needs had been developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care and distressed behaviours. However, information was not available with a support plan for a persons' needs as they became more dependent for example about mobility and moving and assisting or for communication. Risk assessments were not in place for all identified risk with information about how to reduce the risk transferred to support plans such as for the management of epilepsy or self-harm. Some support plans showed they had been written in 2014 or 2015 and they did not all show they had been up-dated since then to accurately reflect people's current needs. Not all records looked at contained information about people's communication needs or comprehension where they may require support. Support plans were in place that provided some details for staff about how the person's care needs were to be met. However, not all support plans provided detail of what the person could do to be involved and to maintain some independence.

Staff and people we spoke with told us about the freedom people had and how they were being supported to become more independent. All staff had a good knowledge of people's current care and support requirements. However, the support plans did not all provide detailed instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. They did not reflect the extent of support each person required. One person told us, "I do my own washing."

Written monthly evaluations of people's support plans were not all available that showed a person's progress or deterioration during the month. However, staff completed a daily diary for each person and recorded their daily routine and progress but this did not show it was incorporated in support plan evaluations in order to monitor people's health and well-being. We discussed the improvements that were required with record keeping and the registered manager told us they would be addressed immediately. We received evidence of improvements that were being made straight after the inspection.

Other support plans provided a description of the steps staff should take to meet the person's needs. For example, a person who was at risk of choking, but had chosen not to eat a soft diet, their care plan stated, "Staff to be vigilant at meal times, especially at night as [Name] likes to eat in their room."

People were encouraged and supported to engage with a variety of activities and to be part of the local community. They were also supported to go on day trips and short trips away. One member of staff told us a

person had been to Blackpool and was looking forward to going to Edinburgh. Activities included walking, drives out, fishing, bowling, arts and crafts, meals out, going to the pub, shopping, going to the races, swimming, gardening, cinema, concerts, theatre trips and going to discos. One person told us, "I am going to Berwick tomorrow." Another person told us, "I like putting a bet on the horses." Other peoples' comments included, "I am going out for lunch to the dog racing" and "I love walking. I am going to Newbiggin [by the sea] for a walk and to have fish and chips tonight."

The provider had a complaints procedure which was available to people, relatives and stakeholders. A record of complaints was maintained. People told us they could talk to staff if they were worried and raise any concerns. One person told us, "I would talk to staff if I was worried."

Information was available about people's end-of-life wishes to inform staff of people's wishes at this important time.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post who had become registered with the Care Quality Commission in April 2017.

The registered manager who was also the provider was fully aware of their registration requirements and notified the Care Quality Commission of any events which affected the service.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we accessed the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a cooperative and transparent way.

The registered manager told us audits were carried out by the quality manager to audit a sample of records, such as support plans, complaints, accidents and incidents, medicines records, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

We considered care records needed to be audited more frequently to ensure the quality of recording and to ensure they accurately reflected people's care and support requirements. Records and support plans needed to be up-dated and information transferred to new records to ensure they reflected the current name and placement of the person. This was rather than just using the records from people's previous placements. We discussed this with the registered manager who told us it would be addressed.

Other auditing and governance processes were in place to check the quality of care provided. A compliance manager was in place and a quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on staff training, medicines management, accidents and incidents, infection control, nutrition and health and safety.

The registered manager was supported by a management team that was experienced, knowledgeable and familiar with the needs of the people receiving support. The registered manager and compliance manager were based at the location office. They had regular contact with one another and the service managers ensuring there was on-going communication about the running of the service. Regular meetings were held where the management were appraised of and discussed the operation and development of the services.

Staff told us regular staff meetings took place and minutes of meetings were available for staff who were unable to attend. Staff meetings kept staff updated with any changes and to discuss any issues.

People were involved in meetings and menu planning and individual's preferences for activities were discussed. We advised more regular meetings should take place with people about the running of the household where people lived in shared tenancies to make them aware of their responsibilities and the expectations of living together compatibly. Meetings also took place to review people's care and support needs and aspirations.

People were asked for their views about the quality of service provision and their views were acted upon. Peoples' comments from a provider's survey for 2018 were positive and comments included, "[Staff] help me to do things" and "Love my flat and happy with staff."