City of Bradford Metropolitan District Council

Wagtail Close

Inspection report

23 Wagtail, 15-21 Wagtail Close
Westwood Park
Bradford
West Yorkshire
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22 January 2016

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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?	Inadequate
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Wagtail Close on 22 January 2016 and the visit was unannounced. Our last inspection of the service was in February 2014 when we found the service to be compliant with the regulations inspected.

Wagtail Close provides both a respite care facility and domiciliary care service to people living with physical disabilities, sensory loss. brain injury or learning disability.

At the time of our inspection the service was providing respite care to one person and domiciliary care to 24 people.

The registered manager for this service left their position in December 2015. A new manager is in post and has applied to CQC for registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 who used the service and staff told us they had confidence in the new manager to give them support.

People who used the service told us they felt safe. Staff were familiar with the systems in place to protect people from risk of harm.

Accidents and incidents were recorded but the systems for the overview of accidents to identify any trends or themes were not being followed.

People who used the service told us staff were very good. However we found staff training was not up to date.

People told us staff were available as they needed them. People using the domiciliary care service did not report any late or missed calls.

People were supported to receive a diet that met with their nutritional and cultural needs. However not all people were supported to receive a diet that met their personal preferences.

People were supported to access healthcare services as the need arose.

People told us staff were respectful of their privacy and dignity needs. However we found the actions of some staff restricted people in their right to choice.

Care was planned with a person centred approach and people told us they were aware of the detail in their care plans and were involved in their development and review.

Complaints about the service were not being managed well and the complaints procedure lacked sufficient detail to enable people to make a complaint.

Governance systems were not being followed to make sure complaints about the service or accidents and incidents were being audited effectively.

We found five breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

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.

People told us they were safe.

Staff had received training in safeguarding people.

There was no consistent overview of accidents.

Safety checks were carried out to make sure the respite facility provided a safe environment.

Is the service effective?

Requires Improvement

The service was effective but some improvements were needed.

Staff had not received up to date training in a number of areas.

Staff felt well supported.

People's capacity to make decisions was assessed.

Nutritional requirements were assessed and peoples cultural needs in relation to their diets were met.

People were supported to access healthcare services as required.

Is the service caring?

Good

The service was caring.

People told us staff were very good and there was no change in the quality of care provided with different staff.

People told us they were involved in their care.

Staff were knowledgeable about people's needs and preferences.

Is the service responsive?

Inadequate

The service was not responsive

People's choices were not always respected or supported.

Care was planned with a person centred approach but care was not always delivered in line with the plan.

Complaints were not managed well.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place to monitor the quality and safety of the safety of the service but there was a risk these would not be effectively maintained if the manager was not given support to maintain them.

Staff and people who used the service provided positive feedback about the acting manager.

Systems were in place to seek the feedback of people who used the service but were not being consistently followed.

Wagtail Close

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 22 January and was unannounced.

The inspection was conducted by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received directly from the service. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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 did not send a PIR on this occasion.

We spoke with four people who were using the service, three members of support staff, one member of the cleaning staff and the manager.

We looked at three people's care records, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the respite care facility and met with three people who use the domiciliary care service in their own homes.

Requires Improvement

Is the service safe?

Our findings

We asked people using both the respite and the domiciliary care service if they felt safe. They all told us they did. Users of both services told us staff knew how to look after them and how to maintain their safety. When we asked one person if they felt safe they said, "Very much so."

We saw guidance for managers about dealing with any accidents or incidents that happened within either of the services. The guidance said all accidents must be investigated by management and significant findings recorded including any actions taken to prevent future accidents. However when we looked at accident forms we saw the form did not include any follow up to the accident and did not include a space for the manager to sign they had seen the form. When we spoke with the manager about some of the accident forms we had seen, they told us they were unaware of them. We saw a summary sheet was in place for managers to complete to inform an annual review of accidents within the service. The guidance with the summary sheet said it was strongly recommended the summary sheet be used as a working document and updated as accidents occurred.

This lack of management and overview of accidents demonstrated a breach of regulation 17 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw risk assessments for managing medicines safely were in place. A person using the respite facility told us they managed their own medicines and we saw the risk assessment for this. Care plans were in place for people who needed support with their medicines. This included information about the medicine and when and how it was taken. Safe storage arrangements were in place for people who used the respite service. People who used the domiciliary care service told us staff supported them in ordering their medicines.

We saw risk assessments had been developed and were included in people's care files. Risk assessments covered areas such as moving and handling, falls, medication and nutrition. Where a risk had been identified, a care plan had been put in place to inform staff of how to mitigate the risk and provide care and support safely. For people who used the respite service, we saw risk assessments were reviewed and updated for each period of respite care. We also saw personal emergency evacuation plans (PEEPs) were developed for people using the respite care facility.

We spoke with the manager and staff about safeguarding. Staff told us they had received training in safeguarding and would not hesitate to make safeguarding alerts themselves if they thought somebody was at risk. Staff were able to describe different types of abuse and told us they had information, including telephone numbers, about how to raise an alert. One member of staff we spoke with was unclear in their understanding of verbal abuse, they told us if this was between people who used the service, they would not recognise this as something that needed to be raised as a safeguarding issue. However, they told us they would always report such incidents to a senior support worker or to the manager.

We saw information in the office about whistleblowing and staff told us they were familiar with the

procedure.

Files relating to staff recruitment were not available at the service as they were managed by Bradford council Human resource department. The manager told us staff were not able to start work before appropriate checks were in place. They told us a minimum of two references were sought along with a Disclosure and Barring Service (DBS) check. This is a criminal record check to make sure applicants are suitable to work within the care sector. Staff we spoke with confirmed checks had been taken before they started work.

None of the people we spoke with raised any concerns about the availability of staff to meet their needs. People using the domiciliary care service said staff were prompt in their arrival and always stayed for the time planned. A person using the respite facility told us staff were always available to them and responded quickly to the call bell.

Staff we spoke with were aware of procedures in relation to infection control and told us personal protective equipment such as gloves and aprons were available as they needed them. We saw stores of these in the office. We found the respite facility to be clean and tidy with appropriate hand wash facilities in place. A person who used the service told us it was always very clean.

The maintenance of the respite facility was managed by the housing association who owned the building. We saw checks of such as water temperatures, call systems and fire safety were completed on a weekly or monthly basis. We saw other records relating to the safety of the environment such as the gas safety certificate were in place and up to date. Any issues with the environment were emailed to the housing association and we saw evidence of these being dealt with promptly.

Checks on hoists were carried out six monthly.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they had confidence that the staff supporting them had been trained to provide them with the care and support they needed. As staff worked between the respite and domiciliary care services, it was important they had training to meet the needs of people in both settings However when we looked at the training matrix we saw staff were not up to date in a number of areas.

The manager told us all staff had received training in managing medicines as some service users needed staff to administer their medicine. However the training matrix showed only two staff had received training in the previous year, some had not received training for several years and 21 staff had not received the training at all. This meant staff had not been trained and assessed as competent to administer medicines.

The training matrix showed that some staff had not had updated training in areas including health and safety, fire safety, first aid and equality and diversity for several years. We saw recent updates had been recorded for the majority of staff in safeguarding, infection control and moving and handling but some staff were still in need of updates in these areas. We saw only three members of staff had received training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This training would be required as staff worked in the respite facility as well as in the domiciliary care service.

This meant that staff had not received the training they needed to enable them to carry out their duties effectively and is a breach of regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received good support from the manager and said they could go to them at any time for advice and support. They told us they received supervision approximately three monthly.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

Deprivation of Liberty Safeguards were only applicable to people using the respite facility. We saw MCA assessments were completed for people using this service and updated on each period of respite care. None of the people using the service were subject to DoLS.

People who used the service told us staff always gave explanation and gained their consent before any care intervention. Two people told us they knew what was in their care plans and knew how their care and

support was to be delivered. One person told us, "I know exactly what is in my care plan and what staff should do for me."

People who used the respite care facility could have their meals cooked in their flat or could order meals from the canteen in the extra care housing facility next door. This facility was also available to people who used the domiciliary care service. A person who used the respite care facility told us staff went through their dietary requirements with them and made sure their diet was suitable to their cultural and physical needs. We saw this person had drinks available to them at all times and that adaptations to enable them to be independent with drinking had been put in place. We saw the risk assessment in relation to this person's nutritional needs was reviewed at each period of respite care. Nutritional risk assessments and care plans were also in place for people using the domiciliary care service.

People told us staff supported them to access healthcare services as required.

The respite facility comprised of three self-contained flats with a communal sitting and dining area. The flats were well laid out to enable people who used wheelchairs to access all areas. Each flat had its own kitchen with cooking and laundry facilities.

Good

Is the service caring?

Our findings

One person who used the respite care facility told us, "I love it here, staff come really quickly when I need them. The quality of care doesn't change with different staff, they are all just as good." They told us staff were friendly and were supportive of the choices they made in relation to their care.

All of the people we spoke with told us staff respected their privacy and dignity and supported them to be as independent as possible.

We saw staff knew people well and we saw evidence they had established meaningful relationships with the people they supported. One person told us how staff supported them to meet their religious and cultural needs and were respectful of these needs.

People using the domiciliary care service told us staff supported them in more than just their physical needs. One person told us about how staff had supported them in making arrangements for a special event in their lives and another told us how supportive staff were in helping them to move flats.

On the day of our inspection staff were involved in supporting a person's move from the respite facility back to their own flat where they would continue to receive support from the domiciliary care service. Staff were working hard to make sure the person had everything they needed in place to make sure they were safe and comfortable when they returned to their flat.

All of the people we spoke with told us they were fully involved in making decisions about their care and support. Two people told us they knew what was in their care plans and told us they were involved in their reviews.

People who used both services told us they knew the new manager and felt they were supportive of their care.

Inadequate

Is the service responsive?

Our findings

One person who used the domiciliary care service told us they had only once had an issue with their call times. They told us they had spoken with the manager about it and it had been resolved quickly. Other people we spoke with did not have any issues about call times.

We saw that care was planned with a person centred approach. This meant the needs and preferences of the person were at the centre of all assessments of need and care planning. A person using the respite facility told us they felt their care was delivered, "Very much" in a person centred manner. They told us staff checked whether their needs had changed at the beginning of each period of respite care and evaluated their care plans accordingly.

We saw the care plans in place provided staff with the information they needed to provide care and support to people in the way they preferred. However in two of the care files we looked at, there were no care plans in place to inform staff of the person's needs in relation to washing and bathing. The people concerned told us this was not an issue as they were able to tell staff exactly how to support them. However the lack of care planning could mean that people did not receive the support they needed should they not be able to communicate them effectively.

One person who used the domiciliary care service told us they were happy with the care they received but felt that staff did not always support them in making choices. They told us they liked to have a bacon sandwich for their breakfast each day and liked to buy ham, sausages and pork pies when they went shopping. They told us a number of staff would not support them to buy or cook these products due to their own cultural requirements or lifestyle preferences. We saw the person's care plan in relation to nutrition said they liked to have bacon sandwiches each morning.

This meant that staff were not providing support that was responsive to the person's preferences and were restricting the person's right to choice. The person said they had raised their concern with senior staff members but nothing had been done about it.

This was a breach of Regulation 9(1) (a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person who used the respite care facility told us they had everything they needed to keep themselves occupied. They told us staff were respectful and supportive of their cultural needs and we saw this reflected in their care plan. People who used the domiciliary care service told us staff supported them in their social and recreational needs as well as their physical needs.

One person told us they would be happy to raise any concerns or complaints they might have with the care staff or would ask to speak with the manager. Another person told us the manager had responded immediately to a concern they had. However one person said nothing had changed for them despite raising concerns. We saw the complaints procedures on display in the respite care facility and in the service user

guides did not include all the details people would need to make a complaint. In particular there was no information about how people could raise a complaint without putting it in writing or making the complaint over the telephone.

We did not see any paperwork in relation to the complaint a person had told us they had raised. This showed us that complaints were not managed effectively and is a breach of Regulation 16 (1)and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The person who managed the service at the time of our inspection had only recently taken on the role of manager from the previous registered manager. The Care Quality Commission (CQC) had been informed of this change. The manager told us they had submitted their application for registered manager to the CQC.

The manager explained they should have two locality care managers working with them to support the management of the services. However both of these people were on leave from the service and had been for some time. This meant the manager was trying to cover the roles of both of these people.

The manager understood their role well and told us they were aware of areas where improvements were needed. We saw evidence they were working to address these areas. For example, the manager was aware of the shortfall in accident monitoring and was looking at ways in which this could be addressed more effectively. The manager was also in the process of updating the staff training matrix and identifying where training and updates were needed.

The manager had oversight of the audits in relation to the environmental safety of the respite facility but had not always signed to say they had seen them. Audits in relation to quality issues had been completed by the previous manager and were due to be done again. The manager told us they would usually be supported in this work by the locality care managers but needed to address this them-self due to their absences. The manager told us they were supported by the provider and had been due to attend a meeting with them on the day of our inspection. However they told us they had not had any one to one supervision with their immediate manager since taking on the role in November 2015.

Despite the manager only being in the role for a short period of time, all of the people we spoke with were familiar with them and told us they had confidence in them.
We saw systems were in place for people who used the respite service to feedback their views after each stay and saw a number of the completed feedback forms. All were complimentary of the service they had received. People who used the domiciliary care service told us they had not completed any recent quality assurance surveys.

Staff told us they felt involved in the service and felt their views were listened to.

Although the manager was aware of areas where improvement was needed in relation to auditing the quality of service, they were not able to tell us about any plans to support them in doing this, particularly in the absence of the two locality care managers.

We found governance systems were not being followed to make sure complaints were managed effectively and accidents and incidents reviewed and analysed. This demonstrates a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were not providing support that was responsive to people's preferences and were restricting their right to choice. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	Accidents were not being consistently audited. Regulation 17 (b) Staff had not received the training they needed to enable them to carry out their duties effectively. Regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Personal care	Complaints were not managed effectively. Regulation 16 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	Governance systems were not being followed to make sure complaints were managed effectively and accidents and incidents

reviewed and analysed. Regulation 17 (2)(a) .