Turning Point

Turning Point - Bradford

Inspection report

Bradford Domiciliary Care
West Riding House, Cheapside
Bradford
West Yorkshire
BD1 4HR

Tel: 01274925961

Date of inspection visit:
19 March 2018
20 March 2018

Date of publication:
08 May 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 March 2018 and was announced.

The last inspection took place in August 2016 where we rated the service as 'Requires Improvement' and found a breach of three regulations relating to Safe Care and Treatment, Safeguarding and Good Governance. At this inspection we found the service had made improvements in these areas and was no longer in breach of any regulations.

This service provides care and support to people living in three '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. At the time of the inspection the service was supporting 10 people.

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 alongside the service 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 were protected from abuse whilst using the service. Staff had received training in safeguarding and understood how to keep people safe. Where concerns had been raised, we saw these had been dealt with appropriately by the service. Risks to people's health and safety were assessed and care plans put in place for staff to follow. People were supported to take positive risks to ensure they could access the community and achieve their goals.

Overall, there were enough staff to ensure people received safe care and support, although some concerns were raised about staffing levels at one of the supported living houses. We saw plans were in place to address this. Safe recruitment procedures were operated to help ensure staff were of suitable character to work with vulnerable people.

Staff received a range of suitable training relevant to their role as a learning disabilities support worker. Staff said they felt well supported by the management team and happy in their role.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were involved in decision making and staff maximised people's choice and control over their lives.

The service worked with a range of health professionals to help ensure individual needs were met. Advice from professionals was embedded into plans of care and systems were in place to transfer care plans and other key information between services.

People and relatives said staff were kind and caring. We observed staff had built a good rapport with people and knew them well. People's independence was promoted and the service worked with people to build their confidence.

People's care needs were assessed and detailed care plans put in place for staff to follow. These were subject to regular review. People had monthly review meetings to discuss their goals; however, these had fallen behind in some cases due to team leader absence.

People had access to a good range of activities and social opportunities. People were enabled to undertake the things they wanted to do on a daily basis.

Relatives and staff told us people had achieved positive support outcomes since being supported by the service demonstrating that it was effective in its purpose, of providing assistance to live independently. We found a person centred culture within the service focused on meeting people's individual needs and preferences.

Systems were in place to check how the service was operating to ensure it maintained safe and effective working practices.

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 safe using the service. Risks to people's health and safety were assessed and plans put in place to protect them. Staff understood people well.

People received their medicines as prescribed and clear records of the support provided were maintained.

Overall, we concluded there were sufficient staff to ensure appropriate care was provided. Staff were recruited safely to ensure they were of suitable character to work with vulnerable people.

Is the service effective?

Good

The service was effective.

People achieved good health and support outcomes from the service.

Staff received a range of training and support tailored to the needs of the people they were supporting. Permanent staff knew people well and their individual needs. Some concerns were raised about the number of agency staff used in some areas of the service.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were assessed and plans of care put in place to ensure healthcare needs were met.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about staff. We saw staff treated people with kindness and compassion. Staff were passionate about the people they supported.

Staff had developed strong relationships with people and knew them well.

Is the service responsive?

Good

The service was responsive.

People and relatives spoke positively about the care and said needs were met. People's needs were fully assessed and detailed care plans put in place taking account of people's individual preferences.

People had access to a good range of activities and community involvement was encouraged.

Is the service well-led?

Good

The service was well led.

People and relatives spoke positively about the way the service was run. Staff said morale was good. It was evident there was a person centred culture embedded within the service, committed to delivering support in line with people's individual preferences.

Systems to check the service were in place and people's feedback was valued and used to improve the service.

Turning Point - Bradford

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.

During the inspection we checked whether improvements had been made following the last inspection in August 2016 where breaches of regulation had been identified.

The inspection took place on the 19 and 20 March 2018 and was announced. We gave the provider a short amount of notice that we would be inspecting, because we wanted to ensure a manager was present in the office and we needed to seek consent before visiting people in their homes. On the 19 March 2018, we visited the provider's offices to look at care related documentation and speak with the manager of the service. On the 20 March 2018 we visited two homes where people were supported to live.

The inspection was carried out by two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service in this case the care of people with learning disabilities.

Prior to the inspection we spoke with both the local authority commissioning and safeguarding teams. We reviewed information held on the provider for example notifications sent to us by the provider. We reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who used the service and three relatives. We spoke with five support workers, the service manager, the registered manager and the training co-coordinator. We looked at three people's care records and records relating to the management of the service including staff training records, audits and meeting minutes.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe using the service. One person said "Yes I do feel safe." A relative said "I am happy that [person] is safe, everyone gets on very well and the staff understand [person]." Another relative said, "Yes he is safe, there are always good staff here." During the inspection one person raised a concern with us about the way they were supported. This had already been identified by the provider earlier in the day, and a thorough investigation was on-going to help ensure the person remained safe. Safeguarding policies were in place and staff had been trained to recognise and report signs of abuse. Staff were able to confidently describe how they would raise a concern and said they thought people were safe from abuse using the service. We discussed safeguarding with the registered manager. They were aware of their responsibilities in relation to safeguarding which gave us assurances the correct procedures would continue to be followed.

Systems were in place to protect people from financial abuse. All financial transactions carried out on behalf of people were recorded and checked by two staff members. Money was kept securely.

Overall risks to people's health and safety were assessed and appropriate risk assessment documents put in place which were subject to regular review. For example risks associated with eating and drinking and going into the community were assessed and clear instructions provided to help staff provide safe care. Staff we spoke with understood the risks associated with people's care, which gave us assurance safe working practices were adhered to. In one case, we identified a person had a lack of robust manual handling plan in place, action was taken to immediately address this during the inspection. People were supported by staff to take positive risks, to maximise freedom and independence, for example going out into the community.

Overall, we concluded there were enough staff to ensure safe and appropriate care. Staff told us that staffing levels were maintained at a safe level and they had no concerns over the current staffing levels in the community. No concerns were raised over staffing levels at two of the three properties people were supported at. However two relatives raised a concern about staffing levels at one of the supported living properties. These comments were: The only thing there is definitely not enough staff, particularly in the mornings, there is only one staff to get them up, give meds, get breakfast, I don't think that is good and "No, there is definitely not enough staff, often there is only 1 member of staff, this is really not enough." The registered manager explained that whilst new staff were being recruited, a member of the management team assisted as a second staff member in the morning to ensure two staff were on duty during the busiest time when people were getting up. We looked at the rota's which confirmed this was the case. Relatives and staff said that agency use was also high at this property. However, we saw that the same agency staff were used to help reduce people receiving care from strangers. We saw new staff had been recruited which would help to address this shortfall.

The provider had a robust recruitment policy and we saw checks were made to ensure staff were suitable to work with vulnerable people. This included receiving at least two satisfactory references prior to commencement of employment and Disclosure and Baring Services (DBS) checks. Where gaps in employment were seen on candidates' application forms, we saw these were discussed at interview. We saw

evidence that people who used the service were involved with the recruitment process and completed an easy read feedback form. This showed people's views were taken into account when recruiting new staff to the team. Staff confirmed these processes were followed.

Medicines were managed safely by the service. A person said, "Staff give me my medication when I need it". One relative said "[person] gets his medication on time every day." Staff administering medicines had received training in medicines management and had their competency to give medicines assessed to ensure they had the required skills to administer safely. Each person had a clear medicine profile in place, which contained detailed information on the exact nature of the support to be provided. This helped staff provide appropriate care. Where people were prescribed 'as required' medicines clear protocols were in place to promote safe and consistent use, these were detailed and included interpretation of body language where people could not verbalise their needs. Medicines were stored securely. Medicine Administration Records (MAR) were well completed indicating people had received their medicines as prescribed. MAR's were brought back to the office each month to be reviewed and audited by the management team.

Relatives said staff supported people to keep their homes clean and hygienic. One relative said "It is spotlessly clean every time we come, which is every day and the bedding is changed daily". Staff had received training in infection prevention and had access to a supply of personal protective equipment.

The service investigated incidents and learnt lessons when things went wrong. Accidents and incidents were recorded on-line which included details, analysis, actions taken and lessons learned from the incident. For example, a number of medicines errors had been recorded and we saw actions including staff disciplinary processes, medicines observations and supervision had taken place following these. The on-line incident reporting system was able to identify incident trends so appropriate actions could be taken to prevent a recurrence. Senior management reviewed incidents and asked for further clarification or actions if required

Good

Is the service effective?

Our findings

Care and support needs were assessed and plans of care created in line with recognised guidance. The service utilised external health professionals to help ensure care was appropriate and in line with best practice guidance. Internal specialists in subjects such as positive behaviour support were also available to ensure the service adhered to recognised practice. People, relatives and staff told us that since people had moved to the service from residential services, they had achieved positive outcomes, increased confidence, independence and more personalised care and support. One relative said "The care is fine, I'm happy with it, they know her well and help her keep up with her appointments". Another relative said" Well since she came here she has really come out of her shell, she is doing more and mixing more."

People and relatives told us they thought permanent staff were well trained and knew their relatives well. One person said "Our staff, there's only two, they know me and know what I like and don't like." A relative said, "The care and support staff are brilliant, she has got them trained and they know her well." We found staff had an in-depth knowledge of the people they were supporting. A number of staff had moved with people from the service's they previously lived in. This helped ensure continuity of care and the continuation of good relationships.

However at one of the properties, one person raised concerns over agency staff they said of regular staff, ""No I don't think the agency staff are trained they don't know what they are doing." A relative said "They use a lot of agency staff who don't know the residents and there is no continuity, this can be unsettling". We saw new staff had been recruited to address this.

Staff received training and updates in a range of subjects including safeguarding, positive behaviour support, epilepsy, support planning, Mental Capacity Act (MCA), food hygiene and infection control. Staff new to care or those that did not have National Vocational Qualification Level 2 in health and social care were enrolled on the Care Certificate. This is a government-recognised training scheme, designed to equip staff new to care with the required skills for the role. We looked at staff training records and saw training was up to date or booked and records indicated when training was due. Training was provided using a mixture of on-line training and face to face sessions held at the training rooms at the provider's head office.

New staff received a four-day induction programme, which included initial training, familiarisation with policies and procedures, and shadowing an experienced staff member for a number of shifts, dependent upon their experience. Staff said they were supported to do further qualifications.

A programme of supervision, appraisal and competency checks was in place. The policy stated supervisions were to be completed every six to eight weeks. However, we saw in staff files and the registered manager told us some supervisions were not always completed in this time frame due staff constraints. This had been identified at audit with actions put in place to rectify and update these areas. We saw supervisions covered topics such as concerns, areas for improvement, staff development and training.

People praised the food provided by the service. One person said "Food is nice. Can choose what I want"

and another person said, "The food is alright, it's meatballs and pasta tonight, I like chicken best". Menus were created at each property based upon people's likes and preferences. People were supported to be involved in the preparation of food to promote their independence. Where people had been identified as being nutritionally at risk, detailed plans of care were created and other professionals such as GP's and dieticians involved. We saw one person who was at risk, was prescribed a nutritional supplement which staff consistently gave them. Their food input was robustly recorded and weight monitored. They had gained weight since joining the service. Staff told us they thought this was because they were able to deliver a more person centred mealtime experience now and as a result the person was more settled at mealtimes.

The service worked with a range of health professionals to help ensure people's healthcare needs were met. This included GP's, community nurses and speech and language therapists. We saw plans of care included their input to help people achieve the best possible outcomes. Each person had a health action plan in place. A health action plan is designed for people with learning disabilities to help ensure they achieve good health outcomes. These were regularly reviewed and demonstrated each person had a range of health checks including an annual review of their health with their GP. Relatives said healthcare needs were met by the service. They said they were always informed if there was any change in their relative's health.

The service was implementing the 'red bag pathway' to help ensure people's needs were met if they were admitted to hospital. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with resident. The standardised paperwork will ensure that everyone involved in the care for the resident will have necessary information about the resident's general health. We saw concise documents on people's needs had been created to ensure this information could be promptly passed between services.

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 the case of Domiciliary Care applications must be made to the Court of Protection. The service had worked with social workers to make a number of applications to the Court of Protection. At the time of the inspection none of these applications had been assessed and there were no DoLS in place. We saw care was delivered in the least restrictive way possible and people's freedom and independence encouraged.

Where the service suspected people lacked capacity, capacity assessments were undertaken for example around personal care and medication and finances and where people lacked capacity, best interest processes had been followed.

Good

Is the service caring?

Our findings

People and relatives said people were cared for by kind, compassionate and caring support workers. Comments included: "everyone is nice to me," "Yes we feel confident, they really do care," "Oh he is looked after very well, he loves it here, and it puts our minds at rest that he is happy," "I really like it, and my daughter is very happy she loves it here," "I feel confident with most of the staff, they are so kind, she wanted to go to a relatives wedding and they accompanied her so that she could attend."

During visits to people's homes we observed staff supporting people. There was a good atmosphere with staff engaging people in conversation. People appeared relaxed and comfortable in staff company. People's privacy was respected and staff asked for permission before doing things or entering private spaces such as their bedrooms. Staff supported one person to use a call buzzer to ensure their privacy was respected. It was agreed with staff that the person only wanted care and support when they activated the buzzer and didn't want checking on during the night. This helped ensure the person's privacy and maximise their independence.

Staff we spoke with demonstrated a commitment to providing person centred and compassionate care. They spoke proudly about the people they were supporting and the things they had achieved since moving into supported living. This led us to conclude staff were passionate about the people they were supporting. Staff knew people well and had developed good positive relationships with them. Information on people's backgrounds was recorded to help staff provide personalised care. People's care records were detailed and evidenced that they had been involved sharing their preferences on how they liked care to be delivered. A number of staff had transferred with people from their previous place of residence to support them, this ensured continuity and familiarity.

Care and support was focused around increasing people's independence and confidence. We saw people were encouraged to help out around the home, for example tidying, cooking and cleaning and were encouraged to do as much as they could for themselves for example during personal care. Care records confirmed increasing people's independence was a key goal of care and support plans.

People and relatives said people had control over their own lives. One person said "We are our own boss" and told us they were able to do as they wanted. We saw people were able to get up and go to bed when they wanted and support with these routines was tailored around when people wanted to do them.

People's views were respected and we saw care, support and community activities were centred around ensuring people's views were acted on. People had review meetings and house meetings where they could air their views, although these had fallen behind at one property due to the team leader being on long term absence. The service tailored communication techniques to each individual to promote choice and control over their lives. For example, pictorial cards were used to help people choose food and activities and a form of Makaton used with another person. Staff were familiar with each person's individual communication techniques.

We looked at how the service worked within the principles of the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under this legislation. Management gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to culture. For example, one person was supported to have a halal diet.

Good

Is the service responsive?

Our findings

People and relatives said care and support was appropriate and met individual needs. One relative said "We think the care and support is very good in fact it's excellent, we know that [person] is happy here, the staff understand all [person's] needs. [Person] has improved greatly since [person] has been here." Relatives said that personal care needs were met by the service.

People's care needs were assessed and clear and detailed care plans put in place to support staff in providing appropriate care. This included person centred information on how the person liked to be supported, focussing on their likes and dislikes. Daily records of care showed care was delivered in line with people's needs and preferences.

Care plans were subject to regular review and people and relatives said they felt involved in planning care and support. Relatives said communication was good, for example one said "I definitely feel confident in the staff because they phone me. They notice if she is unwell or unhappy, she can't tell them she has no communication." Another relative said, "We have been involved in the care plan from the beginning and we have six monthly reviews." Another relative said "I am her appointee and I am involved with her care plan, we have a review every year."

People had monthly review meetings with their key worker. These were an opportunity to discuss the setting of goals, evaluating previous goals, discussing care and support plans and any concerns. Whilst these were a good mechanism for support planning, at one of the homes where people were supported, they had not been recently completed due to the team leader being on long term absence. We saw a plan was in place to address.

We saw people enjoyed participating in a range of activities according to their preferences. For example, one person was supported to attend their local gym and others enjoyed baking, cooking, trips out, pampering sessions and helping to choose the colour scheme and decorate their bedroom. One person said "It's alright here I have my own room and stuff, there is stuff to do and I go out a fair bit, I go to the Gym and I have a personal trainer." A relative said "Overall he has a good quality of life here, he goes out quite a bit, he has four days at a resource centre, goes shopping, for pub lunches, and they take him to the Rugby, and he has his own purpose built room." Staff told us that people had enough to do and regular went out into the community. During the visits to people's homes, we saw people were busy and involved in activities throughout the week.

The provider had an involvement charter in place which promoted involving people to the maximum extent possible in their care and support. We saw these principals were adhered to. Two people who used the service attended regional meetings looking at how services were delivered. People were involved in the recruitment of staff and there was a culture of planning care and support with the person at the heart of the work.

A system was in place to log, investigate and respond to complaints. People and relatives spoke positively

about the service. One relative said "We haven't had any concerns but if we did, we would speak to [team leader] here or the social worker we can talk to either of them." Another relative said "If I had any concerns I would let the staff here or [manager] know, but I haven't had any." The complaints process was available in easy read format for people who used the service. We saw one informal complaint and two low level concerns had been documented over the last year. These had been investigated, the complainant responded to and actions taken as a result of the investigation.

We looked to see how the service worked within the Accessible Information Standard. The registered manager explained how some people who used the service were 'involvement champions' which meant they were involved in devising ways to ensure people's wishes and thoughts were communicated and listened to with actions taken via the 'people's parliament'. The registered manager told us some people used signs and gestures to communicate and receive information and said, "It's just getting to know people's communication."

People had end of life care plans in place, although some of these required more personalised detail adding to them. We spoke with the registered manager about the need to update these.

Good

Is the service well-led?

Our findings

People, relatives and staff told us people had achieved positive outcomes since the service had opened in 2016 and people had moved from residential care into a supported living model of care. One relative said "I think this place is brilliant, I was apprehensive at first whether it would work for her or not, but she seems so much happier than she was at [care home]". A staff member told us a person they supported had become more self-confident since the move. This gave us assurance that the service provided good quality care and achieved effective outcomes.

Most people, relatives and staff spoke very positively about the service. One staff member described the service as "wonderful" and another staff member said, "we are such as good team, we pull together, the manager is an amazing manager, she is exceptional. " Some staff said that one of the homes people were supported in needed more staff and a more consistent staff team. We saw plans were in place to address this.

There was a person centred culture focused around helping people to become more independent and be involved in the care activities they wanted.

A registered manager was in place, who was supported by the service manager. Peoples, relatives and staff spoke positively about the way the service was managed. One relative said "I know [service manager] she comes in frequently and is very approachable". Another person said "The manager is [service manager's name] and she is extremely approachable". Two team leaders oversaw the three supported living houses. At the time of the inspection, one of these staff was on long-term absence, which meant some processes such as reviews were not up-to-date. We saw plans were in place to address this. However, we did not identify any impact on people as a result of this.

A range of quality checks were made to ensure the service was running smoothly and any improvements were actioned. For example, care records, medicines, care records, staff files were completed monthly and actions taken where required. Monthly house checks were completed by managers from other services and included reviews of quality, health and safety, fire, food safety, water checks, vehicle checks and environmental risk assessments. We saw out of hours checks were also completed to ensure the service provided the same levels of care at all times. We saw where actions had been identified these were included in the annual improvement action plan with time frames for completion.

The provider used a number of tools to gauge people's perception of the service quality and include people in the running of the service. This included house meetings, annual, service user focus meetings and a bi-monthly 'people's parliament' for people to discuss what was important to them. Two people attended people's parliament. All of these were minutes in easy read formats. This meant people were actively involved in the quality improvement of the service. An annual relative's survey had recently been sent out and only one response had been received at the time of our inspection. However, this gave positive feedback about staff, care and support, communication and their involvement with the service.

Team meetings or team briefings were held regularly and staff signed to say they had read and understood the information in these. We saw these were an opportunity to discuss concerns and get key messages to staff, such as reminding staff to complete incidents forms on-line. We saw a date had been booked to discuss results of the recent annual staff survey with people who worked at the service. We saw results had been collated and positive comments had been received, including, 'I feel confident confiding in [service manager],' and, 'Very approachable; easy to talk to."

We saw the provider held regional Health and Safety Group meetings four times a year to discuss areas for improvement, updates and actions. These were used as a forum for learning and driving improvements within the services as well as sharing best practice.