Cambridgeshire County Council

March Supported Living Scheme

Inspection report

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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

Overall summary

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, and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the scheme.

This unannounced inspection took place on the 22 July 2014. At our previous inspection in April 2013 we found the provider was meeting the standards we looked at.

March Supported Living Scheme provides a scheme for up to 21 people with a learning disability. There were 14 people being supported by the scheme when we inspected. The scheme had a registered manager. A

Summary of findings

registered manager is a person who has registered with the CQC to manage the scheme and has the legal responsibility for meeting the requirements of the law; as does the provider.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that people who used the service had their capacity to make day-to-day decisions formally assessed. At the time of our inspection no one living at the scheme had needed to be lawfully deprived of their liberty.

People's needs were assessed and this information was used when compiling each person's care plan. This enabled staff to support people using the scheme in a consistent way.

Staff's knowledge of safeguarding vulnerable adults (SoVA) procedures showed us people could be confident any concerns would be reported to the appropriate authorities.

People's privacy and dignity was consistently respected by all staff. This was by always ensuring that staff had obtained valid consent from each person before any care or support was provided, including knocking on the person's door.

The provider had a complaints procedure in place in an appropriate format and if required, people could be supported to raise a concern or complaint. The provider had not received any complaints since our previous inspection in 2013.

The provider had a robust recruitment process in place. Records we looked at confirmed staff were only employed after all essential safety checks had been satisfactorily completed.

The provider had arrangements and systems in place to assess the quality of scheme it provided. This included reviews of people's care using information in an appropriate format.

Summary of findings

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 scheme was safe.

Staff were knowledgeable about recognising and reporting abuse and liaising with the local authority and the CQC about any safeguarding or potential safeguarding concerns.

People were supported by a sufficient number of staff who knew people well and this ensured a consistent standard and safety of care.

The scheme only employed staff after all the required and essential safety checks had been satisfactorily completed.

Is the service effective?

Good

The scheme was effective.

People were supported with their independent living skills to ensure they had the ability to do the things they liked and also when they wanted to do them.

Staff were provided with the right skills to support people living at the scheme. This included training on various subjects including managing behaviours which challenge others, dementia care and safeguarding adults from harm.

Staff confirmed that their induction, supervision and appraisals had been thorough and had enabled them to perform their roles effectively.

Is the service caring?

Good

The scheme was caring.

People were supported and involved in making decisions about their care and were enabled to be as independent as possible. Staff responded to people's requests with warmth and respect in a consistent way.

Staff had a clear understanding of each person's needs and how these needs were met. People were treated with dignity and respect.

Is the service responsive?

Good

The scheme was responsive.

The scheme ensured that staff were provided with the training to ensure that people's needs were met in a reliable way.

People were supported when they needed to use other health care schemes such as the hospital. People were supported with care that was relevant and up to date.

Is the service well-led?

Good

The scheme was well led.

The provider had processes in place to ensure that care plans, accidents and incidents were reviewed and that any required action was taken to ensure that the care provided was consistently good.

Summary of findings

The management team provided good leadership and ensured a high standard of care for people living at the scheme.

A quality assurance system was in place to monitor and improve the quality of scheme and care it provided. This was to ensure the required standard of care was continually under review.

March Supported Living Scheme

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

This unannounced inspection of the scheme on 22 July 2014 was undertaken by one inspector.

We spoke with seven people, five care staff, a Senior Support worker and the operations' manager. We also spoke with two health care professionals. We also received positive comments from the scheme's commissioners. Not everyone who used the scheme was able to talk with us.

This was because some people had complex care and support needs. We were supported by staff, people's care plans and other information to help us with our communication with people.

Before our inspection we were not able to look at the provider's information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements that they plan to make. We did not receive it prior to our inspection due to the registered manager being off work. However, the provider sent us this document before this report was published and showed us that they had plans in place to continue improvements to the scheme.

We observed how people were cared for to help us understand the experience of people who could not talk with us. We looked at four people's records and other records related to people's care including lifting and hoisting equipment safety, the scheme's service user quality assurance survey questionnaire, staff recruitment and supervision records, infection control records and medication audits.

Is the service safe?

Our findings

People told us that they were safe living at the scheme. One person told us, "Why wouldn't I feel safe. The staff look after me and my friends when I am at home and when I am out doing things." Another person said, "I recently had to go to hospital after a fall and the staff made sure I was safe by accompanying me throughout my visits to hospital and with all my other check-ups." This showed us that risks to people's safety were kept to a minimum.

Healthcare professionals we spoke with said, "We have no concerns with the timely reporting of any person's health issues who used the scheme. If we did have these would have been raised at a practice meeting."

Staff we spoke with had a good knowledge of safeguarding adults and how to support them safely. This included knowledge of who and how to report any safeguarding concerns. The same staff had a good understanding of how to ensure that people did not suffer any discrimination. For example, by following the provider's safeguarding and equality and diversity policies.

Following recent case law involving the care of people in the community the provider had made an application under the Deprivation of Liberty Safeguards (DoLS) for one person as their liberty may now have been restricted. The provider was awaiting the decision of their application to the court of protection. The registered manager and care staff followed the Mental Capacity Act 2005 (MCA) and DoLS for people who lacked capacity to make a decision.

The staff training records we looked at showed us that the majority of staff had completed training on the MCA and DoLS and staff we spoke with were knowledge about applying this legislation when required.

There were risk assessments in place which had, apart from one relating to a person's fall, been subject to regular review which meant that people's safety was kept under review. Where risks were identified for things such as people accessing the local community, travel and transport arrangements, falls, and moving and handling there was clear guidance for staff to follow which meant that people were supported in a consistent way by all staff. This was to ensure that people were kept safe. People were assured they would only be exposed to risks where this was safe to do so.

People's care plans were clear, detailed and provided guidance which any staff would be easily able to follow. People's care plans provided guidance to staff so that they offered the right support whilst also respecting people's independence.

Emergency contact details for each person's GP, health care worker, key worker and social worker were held at each of the houses where people lived. This ensured that in the event of an emergency such as loss of power at a person's home or a person suffering a fall, the scheme had systems in place to provide emergency support for each situation safely.

From the records we looked at we saw that people's behaviours which challenge others had reduced and in some case stopped completely. Staff told us that this was due to the person being settled where they lived and the activities they were now able to partake in as a result of staff support. We saw from the records we looked at that information and guidance provided for staff to support people who became anxious enabled the staff to support the person in a way that reduced the person's level of anxiety in the most compassionate way.

We looked at four staff recruitment records. We found that these records provided assurance that appropriate pre-employment checks had been satisfactorily completed. The checks included employment references, evidence of staff's good character and completion of a Disclosure and Barring Service criminal records check. This meant that the scheme only employed staff after all the required and essential safety checks had been satisfactorily completed.

People's daily care records we looked at showed us that where staff conducted a shift handover the information was detailed and provided an accurate record of the care people had received during the shift. For example, it detailed information if a person required their medicines before a meal. This ensured that staff administered people's medicines as prescribed in a safe way.

Care staff we spoke with were able to tell us the action they would take if a person was accidentally administered the wrong dose or wrong medicines. This was to ensure people did not suffer any adverse effects and medical support had been sought.

Medicines were held securely in one of the scheme's houses. This was because not everyone who used the scheme was able to safely manage their own medicines.

Is the service safe?

Most people's medicines were found to be clearly identified with a picture of the person they related to. Staff told us some people's photographs had been removed when the new medicines supply had been obtained but they would be replaced as soon as practicable. Some people liked to have their medicines administered in their food as this was their preference. We saw that this had been agreed by the person's GP as it was in their best interests. This showed us people's capacity to make decisions had been appropriately assessed.

We looked at the staff rotas for the scheme. We saw the provider had staffing levels based on people's assessed needs. Where relief staff were used these were always the same and this ensured consistency in people's support. We also saw that at each of the houses within the scheme we visited that there was sufficient staff to safely meet people's needs. One member of staff said, "We were a bit short staffed earlier this year due to sickness but we have enough staff and people are always able to partake in their chosen activities." Records viewed confirmed to us where people required one to one support, additional staff were always put in place. This meant that people could be cared for by staff they knew well and who could meet their needs

Records of how infection prevention and control was managed at the scheme showed us that appropriate and relevant guidance had been followed. This was with regard to storage, identification, disposal and provision of cleaning equipment and correct use of protective clothing and equipment. Audits and checks by managers meant the standard of cleanliness was good. We noted that some weekly checks had not been recorded as having been completed.

Is the service effective?

Our findings

One person told us, “Since I started living here I have become more and more independent. I get to do lots of things including my favourite, woodworking.” Another person who had been out earlier in the day said, “We went out for a picnic as it was such a nice day. The staff know me so well.”

We looked at the health records of four people who used the scheme. We saw each person was provided with regular health checks, including an annual well man or well woman check-up. The healthcare professionals we spoke with, told us that they had no concerns with the timely referrals or request for health care support. This meant that people could be confident that their health care needs would be reliably and consistently met.

Each person living at the scheme had a health action plan. This was in a format that clearly showed each person what their medications were and what they helped the person with. This was to ensure that people were supported at all times with their health conditions. We saw records which showed us people were supported to see, or be seen by their GP, optician, dentist, psychiatrist and chiropodist.

The records we looked at and our observations showed us that staff supported people in a way they liked to be supported. We saw people’s independent living skills were respected. This included people having sufficient quantities of food and drink. For example, where people with differing communication skills indicated or communicated to staff that they needed support, staff knew what each person’s requests for food or drink meant and acted accordingly. One person we spoke with ‘smiled’ when we asked them if they liked their food. Another person ‘nodded’ their agreement. Staff recognised from people’s behaviours if they were communicating ‘Yes’ or ‘No’.

During our observations throughout the day we saw that staff were all very knowledgeable about how people liked to be cared for and supported. We also saw that people at risk of malnutrition or dehydration were effectively supported to have sufficient quantities of food and drink.

Changes were made to the scheme to ensure people’s needs were met. Staff told us the good thing about working with the scheme was seeing the difference they made to people’s lives with the involvement of health care professionals. They went on to say that where any specialist training was identified such as people living with epilepsy, dementia and autism that this was provided.

Staff received a comprehensive induction where their competence was assessed at six, eight and twelve weeks before they were signed off as being suitable to work at the scheme. Staff told us the training and support that they had received, enabled them to provide effective care. Records we looked at demonstrated that staff were supported in their roles with annual appraisals and regular supervisions. These records showed us that staff were supported to do their jobs and provided with development opportunities to improve their health care skills.

The staff training records we looked at and the staff we spoke with demonstrated to us that the needs of people who used the scheme were met with a corresponding level of staff training. Training included challenging behaviours, managing people’s epilepsy, autism, dementia and medicines administration. We saw staff had been assessed following their training to ensure they understood the issues and were competent. People’s care and support needs were reliably and effectively met by staff with the right skills.

People’s health risks such as those for medicines, specialist food diets or food allergies had been identified and recorded. We saw staff supported people to ensure that people were not exposed to any unnecessary risks. For example, to ensure that people received sufficient quantities of food and drinks throughout the day and night. Records viewed confirmed this to be the case.

Is the service caring?

Our findings

One person repeatedly asked to speak with us and at no time did the staff dismiss this person's requests. Staff responded patiently and with sincerity to the person's questions and prompts. Other people were seen to have their needs met effectively and according to their assessed care and support needs. One person told us about their recent experience of being supported with a hospital visit and the care they had received. They said, "Whilst I have these care needs I need extra support from staff to ensure that I still maintain a good level of personal hygiene."

People were supported to be as independent as possible. For example, one person returned to the scheme later in the day and told us they had been to their day centre. Two other people told us they had not been out as it was the holidays and their day centre was closed. The same two people went on to show us some things they had made, including name plates for their bed rooms. One person said, "Woodwork is my favourite past time and I have made lots of things."

We observed people with more complex needs at one of the scheme's houses. We did this to help us understand the experience of people who could not talk with us. Our observations showed staff's interactions with people were provided with the utmost compassion and in a kind and sincere way which respected people as individuals. People were supported with their eating and drinking with warmth which respected each person's dignity. People were not rushed and had the opportunity to indicate whether they wanted more food or drink.

Four people's care records we looked at showed us that each person's needs had been assessed before they started to use the scheme. This was to ensure the scheme could safely and reliably meet all their care and support needs. We saw the care provided was based upon this assessment, staff's knowledge and awareness of people and also their life histories. This included issues that caused people anxieties, what the calming measures were, what their likes and dislikes were, and medicines and food allergies. People could be confident the quality of their care was based on a sound foundation.

We found that these care plans were based upon the individual and were in appropriate formats including picture and easy read. This enabled a greater level of involvement of people in their care and support needs. People's communication skills were clearly identified and also any body language or behaviours that staff needed to be aware of. One member of staff told us they used formal sign language which had been adapted in a way people preferred. During our observations we saw that all staff used these communication skills to good effect.

People were offered the option to lock their bedroom door, although staff had access to rooms in the event of an emergency. Most people however had chosen not to lock their doors. Throughout our inspection we observed people's dignity was supported and people's privacy was consistently respected.

Although there was no regular advocacy scheme provided for people using the scheme, we saw that advocates' contact details were provided for people, their relatives or social workers to request advocacy support if this was ever required. This was for people who were not able to speak up for themselves and those who had no surviving families or relatives. One person said, "If I ever have anything that bothers me I just ask staff and they help me straight away."

The provider told us they had recognised the need to explore the sensitive subject of people's end of life wishes. Where people lacked the capacity to make these decisions and also where family or other relatives were no longer available, we saw that best interests meetings had been held. The operations' manager went on to tell us that sometimes this was due to circumstances outside their control and this was only used as a last resort after all other possible avenues had been explored. This ensured decisions about people without an enduring power of attorney were only made where it was in their best interests.

Is the service responsive?

Our findings

Staff we spoke with told us they knew everyone's needs who used the scheme. This helped ensure if a care worker was off that any other staff member was able to respond to people's needs in an appropriate way. One person we spoke with said, "I do have a favourite care worker but they all care for me equally well." Another person we spoke with said, "I am always involved with my care planning. Once I am happy with it I sign my name to say that I agree with it." Staff went on to tell us how each person's care differed and that their plans of care reflected these differing needs.

Mental capacity assessments had been completed for each person within the scheme. This and staff's understanding of the Mental Capacity Act 2005 meant that people were supported with the person's agreement. Best interest meetings had been held for situations where people's needs had changed. These meetings were attended by people's relatives (where possible), social workers and where required, health care professionals. People were assured they would be provided with care only where they had provided valid consent or where this was in their best interests.

We asked how staff recorded and managed people's changing needs. Staff told us, and we saw, that a daily communications log was used to ensure people did not have any aspect of their care omitted. People we spoke with told us they were able to do what they liked whenever they wanted. Wherever possible people were encouraged to have holidays where this was appropriate and according to their support needs. This included trips to see their families and friends.

We saw that people were assisted by staff to personalise their own rooms and each person could contribute suggestions for the decoration in other rooms shared by people. This included music collections, things people had made and family photographs. Of the four people's bedrooms seen (with the person's permission) we saw and were told they had chosen the colour schemes. One person told us, "My favourite thing is my bedding which I got to choose."

We saw from the records we looked at that the provider (Cambridgeshire County Council) of the scheme had not had any formal complaints submitted to it since our last inspection. The complaints process followed their guidelines for people living at the scheme. One person said, "If I need to complain I just tell the staff and things get sorted out quickly. I rarely have to complain though."

Activities people took part in varied from attending employment, gardening, golf, bowling, cinema and day schemes where people learned independent living skills such as cooking, as well as more ordinary trips to the shops and garden centre. People took part in activities that were important to them.

People were supported when they needed to use other health care services such as the hospital. Staff supported people with their hospital visits according to people's needs. Important information which was used to support people in the event of an emergency was found to be relevant and up to date. This ensured that important information about people was always available to whoever was responsible for the person's care.

Is the service well-led?

Our findings

Staff recruitment records viewed and staff we spoke with showed us that most staff had worked for the scheme for many years and staff turnover was low. One care worker said, "We are a team but if there are any concerns I feel well supported by management especially whilst (registered manager) is off."

People we spoke with told us that they could speak with staff at any time about their concerns or suggestions. One person said, "If anything in my room needs improving or fixing the staff soon get things sorted for me." Another person said, If ever there was anything that worried me I would just talk to my carer."

Throughout our inspection and observations we found that care staff and managers we spoke with were all well motivated in the way they provided people's care. We also saw that staff were passionate about working at the scheme and making a difference to the people who lived there.

The scheme had a registered manager in post since 2010 but had reported their recent absence to the CQC. This showed us that the provider submitted notifications when required. (A notification is information about important events the provider must inform us about by law). From speaking with people, staff, scheme commissioners and health care professionals we found that whilst the registered manager was absent that the provider was ensuring that the quality of care provided met the required standard. Responsibility for the registered manager's duties had been effectively delegated between those staff who were able to make decisions at the appropriate level. This showed us that the provider demonstrated good management.

Records of accidents and incidents viewed showed us where incidents had occurred, action had been taken to ensure that people's care was safe and systems had been put in place to prevent any potential recurrence. Records showed us where people had experienced a fall or where their health condition had changed, appropriate steps had been taken to reduce the potential for recurrence or to ensure people's health improved. Examples of this included regular weight checks to identify if anyone was at risk of not maintaining a healthy weight. This was a precautionary measure the provider had taken in response to previous incidents.

The provider sent us information about the development of a new version of the staff handbook. This included things such as the vision, values and priorities for the scheme, roles and responsibilities, induction procedures, CQC standards and also quality monitoring standards for the scheme. The provider showed us how they planned to identify good practice which they would share throughout their other locations. This was based upon the CQC's new approach to inspecting and demonstrated to us how the provider was to ensure that a good quality of care, or better, was provided.

We saw audits had been completed in areas such as infection prevention and control, medicines administration, health and safety, fire safety and people's care plans. We saw where improvement actions had been identified that plans were put in place to ensure any potential for reoccurrence was prevented and for improvements to be made.

Staff we spoke with told us that if ever they had the need to whistleblow (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work) on poor standards of care if this was required they would have no hesitation in doing this. All of the staff we spoke with told us the manager's door was always open and if ever they had any concerns the manager listened and acted promptly if this was required. Staff meeting minutes we looked at showed us staff were able to comment on what they felt needed changing or improving. Staff we spoke with told us they were confident that if they had any concerns or comments that management would take action.

Relatives told us that they had very regular communication with the managers and any changes or improvements did not have to wait for a formal meeting. One relative said, "I can't remember the last time I had to suggest something. The manager knows our [family member] at least as well as we do." Records we looked at showed us if a person wanted to complain or were unhappy they communicated this to staff in a way the person preferred. For example, this was achieved through body language or telling staff they were not happy.

Is the service well-led?

Records of meetings for people who used the scheme showed us that people's views were sought in a way that respected people's abilities and was also in a format that involved people as much as possible. We saw that suggestions for new equipment had been actioned. One person showed us their new bedding and that they were going to get new curtains soon.