Wakefield MDC

Peripatetic Service - Sherwood Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 and 15 May 2018 and was announced. Sherwood Court registered with the Care Quality Commission (CQC) on 20 April 2017 and has not been previously inspected. There were 32 people who used the service at the time of inspection.

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People using the service lived in their own flat in a purpose built complex and had access to care and support 24 hours a day, seven days a week. There was a communal dining area for people to use at lunchtime if they wished.

A registered manager was in post at the time of inspection. 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.

PRN, 'when required', protocols were not in place to guide staff as to when these medicines should be given. Systems and processes in place to manage medicines were not always safe or effective. We found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risks associated with people's care were identified and managed. However, we found one instance where a risk assessment was not in place for a person with challenging behaviour.

People were supported by sufficient numbers of staff to meet their needs. Staff underwent appropriate checks prior to starting work. Staff received an induction, regular supervision and training.

The service followed the principles of the Mental Capacity Act. However, we made a recommendation to ensure the information regarding best interest meetings, capacity assessments and Lasting Power of Attorney documentation, to support relative's involvement, were clearly recorded within people's care records.

It was clear staff knew people well. People told us they felt involved with their care. We saw people had service user guides within their homes. We saw there was clear guidance in care plans around people's communication needs. People's privacy, dignity and independence was respected. We observed staff knocking on people's doors and waiting to enter.

People's care plans and daily notes were not always person centred and had a tendency to be task driven. We made a recommendation that the provider looked at ways to ensure people's care plans were person centred and people's wishes around their end of life care was recorded.

The provider had a complaints policy and procedure. People were aware of how to make a complaint. Any complaints and outcomes were recorded individually on a person's contact journal. This made it difficult for the registered manager to maintain an overview of complaints.

Staff were happy working at Sherwood Court and felt listened to by the management team.

The registered manager and provider did not have sufficient quality assurance systems in place in order to have effective oversight of the service.

We found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 always safe.

The systems and processes in place to manage medicines were not always safe or effective.

Risks associated with people's care were identified and managed. However, we found one instance where a risk assessment was not in place for a person with challenging behaviour.

People were supported by sufficient numbers of staff to meet their needs.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and training.

The service followed the principles of the Mental Capacity Act. However, this information needed to be clearly recorded within people's care records.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People's independence was promoted and they were involved about matters relating to their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in the care planning process.

The care plans and daily notes were not always person centred and had a tendency to be task driven.

The provider had a complaints policy and procedure. People were aware of how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not operate effective systems and processes to make sure they assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users.

Staff told us they felt supported and listened to.

Peripatetic Service - Sherwood Court

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 checked 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 was a comprehensive inspection. The inspection took place on 14 and 15 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the registered manager is not based at the office and we wanted them or a representative to be available.

The first day of inspection was carried out by two adult social care inspectors and one adult social care inspection manager. The second day of inspection was carried out by two adult social care inspectors.

We reviewed information we held about the service, such as notifications and information from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England. We contacted commissioners, the local authority safeguarding team and the clinical commissioning group prior to inspection.

The registered provider had been asked to complete a Provider Information Return (PIR) and they returned this to us prior to 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.

During the inspection we spoke with four people who used the service, one relative, four members of care staff, a practitioner (supervisor), the person responsible for the rota, the base co-ordinator and the registered manager.

We looked at a variety of documentation including; care documentation for three people, three staff

recruitment files, meeting minutes, documents relating to the management of medicines and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

Staff completed training in medicine management and had their competency checked. We looked at a sample of medicine administration records (MAR). These were appropriately completed and signed by staff. With people's permission, we looked at their medication. We found eye ointment which was required to be placed in a fridge was not stored appropriately. This meant the medicine may not be effective. The base coordinator agreed the medicine should be stored in a fridge and told us they would look into this. We identified a medicated cream which had an illegible label. This meant the instruction and doses may not be followed. The person told us, "I don't use this anymore." The base coordinator removed the cream immediately and stated medicines should not be used if the label cannot be read.

We found PRN, 'when required', medicine protocols were not in place. This meant there was no guidance for staff to follow so they knew when a person was to be given their PRN medication. This meant there was a risk PRN medicines may not be administered appropriately. We saw one person had a risk assessment in place for medication which had been completed in January 2017. The updated version for 2018 was in the office. This was later placed in the person's file.

One person required one of their medicines to be given 30 minutes prior to food; however this was not flagged on the MAR sheet. This meant there was a risk medicines may not be given at the appropriate time.

We discussed these issues with the registered manager. They told us they did not have an audit in place for medication. The provider's medication procedure for adult domiciliary services stated, 'The pharmacist undertakes an annual audit of medication practice and systems in the service and provides recommendations and advice where required'. The provider was not following their own policy.

The issues identified above demonstrate the systems and processes in place to manage medicines were not always safe or effective. We concluded this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw risk assessments were kept up to date and covered areas such as falls, medicines, skin integrity and communication. There was clear guidance around the number of staff and equipment required. However, in one care plan we found no information regarding what setting their specialist airflow mattress should be set at to guide staff.

Staff were aware how to report incidents. Accident and incident forms were completed and filed within a person's individual contact journal. The registered manager stated staff were encouraged to fill in the incident forms online. We were informed accidents/incidents were investigated and there was a hierarchical sign off and the information was sent to the provider's health and safety team. However, there was no clear evidence of lessons learnt or manager oversight. The registered manager showed us a spreadsheet which briefly summarised incidents. There was no evidence to show these had been analysed to look for patterns and trends and what action had been taken to prevent incidents reoccurring. For example, there were nine incidents of a person being verbally abusive. The only follow up recorded on the spreadsheet was 'social

worker aware'. We looked at the person's care record and risk assessment and found there was nothing in place regarding managing challenging behaviour. This person's hospital information sheet did not reference the challenging behaviour and how this should be safely managed. The registered manager told us the person was going to be re-assessed as they did not feel the service could meet their needs. They told us they would put the risk assessment in place as a matter of priority.

Everyone we spoke with told us they felt safe. One person said, "I feel safe; Staff are here to help you." One member of staff told us, "I think it's brilliant here. I would have my own family in here." Staff explained the signs of abuse and what they would do to make sure people were safeguarded. Staff knew who to report any concerns to both within the organisation and to external agencies, such as the local authority safeguarding team. The CQC had not received any safeguarding notifications; however the registered manager was clearly aware of the circumstances in which to submit a notification.

Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

There were enough staff to meet people's needs. Although the care was delivered in one building staff had five minutes travel time between calls. People told us there were enough staff to meet their needs. One person said, "There is always someone when you need them." We saw people had their own pendants and one person said," I have a buzzer round my neck if I need someone. They come very quickly."

There was a dedicated member of staff who organised the rota. If emergency cover was required there were the practitioners (supervisors) and the care staff who worked at the provider's other services that could be called upon. The computer system used alerted the managers if there were any missed calls to enable these to be picked up. The system was able to produce reports which were used at people's care reviews to evidence whether an increase or decrease in their care package was required.

Staff had access to personal protective equipment (PPE). We observed staff wearing PPE in people's room when supporting with any personal care needs.

Good

Is the service effective?

Our findings

People had their needs assessed prior to the service delivering care. This was completed in conjunction with the registered manager, base coordinator, the social work team and the tenancy scheme manager to ensure the placement was suitable. People had their care reviewed by the provider on an annual basis. People had access to other healthcare professionals when needed, such as occupational therapists and GPs.

All staff had a learning and development pathways folder which was used as part of their induction and to record any on-going training. We spoke with recently recruited staff who told us their induction and shadowing period had been thorough and prepared them for their role. Staff received appropriate training in areas such as fire safety, risk assessment, medication, safeguarding and incident reporting. Staff completed the Care Certificate and completed a period of shadowing prior to delivering care. The Care Certificate is a set of standards for social care and health workers. Staff told us they received regular supervisions, including observational ones. Staff confirmed they had achieved or were working towards the Care Certificate. The evidence we looked at confirmed this.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The registered manager was knowledgeable about their responsibilities under the MCA. They were aware people were free to make decisions and could leave their homes when they wished. They gave an example where one person with dementia wanted to leave their flat at 5am every morning as if they were leaving for work. They arranged a best interests meeting and applied to the local authority for a Deprivation of Liberty Safeguard (DoLS) in order to place a door sensor to alert staff when the person left their room. This was to enable staff to support the person and ensure they were safe. The registered manager was aware when best interests meetings should be held and to involve advocates, other healthcare professionals, the person and relatives (where appropriate).

The staff meeting minutes documented which people had best interest meetings. In one care plan there was information regarding a people's capacity and how to communicate to help them understand and make informed decisions. For example, to repeat things as the person's ability to understand and retain information fluctuated. The information within the care record referred to a relative supporting the person to make decisions but it was not clear whether they had Lasting Power of Attorney (LPA) for health and welfare. A LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

It was evident through speaking with the registered manager, base coordinator and looking at staff meeting

minutes that 'best interest' meetings were held for people. However we did not see these recorded in people's care plans. We recommend the provider ensures there is clear evidence of best interest meetings, capacity assessments and LPA documentation to support relative involvement.

Staff sought permission from people prior to delivering care. If a person refused care they would respect their wishes. However, they would explain and talk to the person about why their care was important. They told us they would try and determine whether there was any underlying reason for refusing care. They would also try again at a different time or try another staff member. Staff would raise any concerns with their practitioner. Staff gave good examples on how they facilitate people's choices. For example, physically showing people clothes or food.

Good

Is the service caring?

Our findings

It was clear staff knew people well. One person said, "They all look after me, I know where they are if I need them." People told us staff were there to support them. One person said, "They support me on a morning with all my personal care needs. The staff are all lovely."

Staff told us no one had particular cultural or spiritual needs at the time of inspection. Although they were aware some people like to attend a regular church service. Staff were aware of how to be sensitive to people's needs. For example, one member of staff stated care times could be changed around periods of fasting.

People told us they felt involved with their care. We saw people had service user guides within their homes. We saw there was clear guidance in care plans around people's communication needs. For example, care plans specified if someone had difficulty hearing and what steps they should follow. For example, staff should make sure they were on a person's level when talking with them.

Everyone we spoke to told us there privacy and dignity was promoted at all times. One person said, "All the staff are lovely and polite, they knock on my door." One relative told us, "We are always made to feel welcome and they look after [name of person] very well. The staff are brilliant." We observed staff knocking on people's doors and waiting to enter. Staff gave good examples of how they respected people's privacy and dignity. For example, by waiting outside the bathroom, covering people with towels and closing doors. One member of staff told us, "I think, deliver care how you'd want your mum to be treated." Staff gave good examples of how they encouraged people to be independent. For example, encouraging people to do things for themselves such as wash their face and hands.

Requires Improvement

Is the service responsive?

Our findings

People told us they were aware of their care plan and they could input into this. There was evidence people contributed to their care planning and support. People's needs were assessed and kept under review. We found some care plans lacked sufficient detail. For example, there was no specific guidance regarding assisting one person with moving and handling needs to bed and the use of their pressure mattress. The care plans and daily notes were not always person centred and had a tendency to be task driven. There was no 'This is me' or background information regarding a person. One care record referred to a person's spouse who had passed away but did not reference the spouse's name. The registered manager told us no one was receiving end of life care. However, there was no evidence to show this was discussed when someone moved into the extra care scheme or at their review. We recommend the provider looks at ways to ensure people's care plans are person centred and document they have asked people about their end of life care wishes.

People were able to choose whether to stay within their homes, go to the communal area for lunch and what activities they wished to do. One person told us they went out and did their own shopping. Another person said, "We can do different things but I don't like to join in I prefer to spend time in my room as my family often visit." Another person said, "We do bowls, bingo, singing and someone comes in every Friday to entertain us."

The provider involved the local authority sensory impairment team where appropriate. For example, the team were contacted to help orientate a person, who was new to the service, to the layout of the building to enable the person to be independent. People's care plans documented visual aids such as magnifying glass for reading to help ensure people could access information.

The provider had a complaints policy and procedure. People knew how to complain. One person said, "Yes I know how to complain, I would if I needed to." It was difficult to determine whether complaints were responded to appropriately because there was not a central place were complaints and investigations were recorded. Any complaints and outcomes were recorded individually on a person's contact journal. The registered manager kept a spreadsheet of the complaint information but this was brief and it was not clear what action had been taken to resolve the complaints. For example, one person had missed their medication at lunch time on two occasions and actions taken stated medicines 'administered at a later time'. We raised this with the registered manager who explained that this had been looked into and an additional call time had been added to prevent this happening again. However, this outcome was not apparent from the overview spreadsheet. We were informed there was no separate recording of investigations and they were recorded on the individual's contact journal. There was not a sufficient overview of complaints. There was not a system in place to identify patterns and trends.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of the inspection. 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 provider's medication procedure for adult domiciliary services stated that managers would inform the CQC of medication errors. There had been eight notifications of medication concerns recorded by the registered manager and none had been reported to CQC. The service had completed their own internal investigations in relation to this and had sent their concerns directly to local authority safeguarding team. The registered manager told us they would only notify the CQC if someone had come to harm. The records we looked at showed the incidents were dealt with appropriately and referred to the local authority safeguarding team. The registered manager told us they would immediately look at their systems and process regarding this to ensure the appropriate notifications were being made to the CQC.

Effective quality assurance systems were not in place. There was no evidence of action plans to show service improvement. The provider did not have an effective system in place to ensure the work of the registered manager and the service was audited.

The registered manager told us they did not have a medication audit in place. The meeting minutes of a practitioners' (supervisor) meeting referenced they'd found not all staff were putting stock balance and signing in relation to medicines. It stated they were to monitor this. There was no system in place for the registered manager to check this had been completed.

The registered manager told us there was no system in place to regularly audit care records to assess the quality of people's care plans and risk assessments. We found the care records were difficult to navigate round and contained outdated information which required archiving. The lack of care record auditing meant there were opportunities missed to identify the issues we had found.

There was no evidence to demonstrate accidents and incidents had been analysed to look for patterns and trends and what action had been taken to prevent incidents reoccurring. There was not a sufficient overview of complaints and there was no system in place to identify patterns and trends.

The registered manager and coordinator told us informal audits were completed on people's record sheets when these were returned to the office. They told us these were reviewed to ensure staff were delivering care to meet people's needs and action taken when required. There was no evidence to demonstrate this took place and there was no area on the form for a manager to sign off or to make comments.

We concluded these issues collectively demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had an overview spreadsheet of service users receiving care which showed when their care review dates with the provider and the social work team were due. They tried to coordinate the reviews. The base coordinator had identified there were a number of outstanding reviews due by social services. They had raised this as a priority with social services.

Throughout the inspection there was an issue with the service's information technology. Internet connectivity was intermittent and extremely slow. This made it difficult to assess information during inspection. The registered manager and coordinator told us this issue was a usual occurrence and they had reported this to the provider as an issue. It was clear this impacted on their ability to get their work completed.

Staff told us they were happy working at Sherwood Court. On member of staff told us, "I love it." Another member of staff had noted there had been significant improvements to the service. They told us it was "more organised. We work together." Staff told us they felt supported by the management team. One member of staff said, "They listen to the team." Another member of staff commented, "I love this team."

Staff told us they were able to provide feedback on the service. This took place in supervisions and team meetings. The provider asked staff to complete online surveys but these were not specific to Sherwood Court. Team meetings also provided the opportunity for staff to provide feedback. We looked at a sample of minutes and saw training, policies and service user needs were discussed. The registered manager explained they planned for their meetings with the coordinators across the services they managed. They showed us an example of the notes they made prior to a meeting where they looked at areas such as training and recruitment to ensure it was kept up to date.

Quality monitoring forms had been completed which looked at areas such as decision making, whether needs were met, call times and duration, carers, respect shown towards the person and their way of life and check they know how to contact office. The registered manager told us quality monitoring forms were completed at reviews but they found this was not the best time to complete them. They were looking into new ways to capture this information. The coordinator meeting minutes discussed people's feedback and they were asked to investigate comments on the form. We saw this had been done, however the information was recorded individually on people's contact journals. There was no overview of this.

The provider held meetings once a quarter to share learning from CQC inspections and to discuss the CQC newsletter and updates.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were weaknesses in the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have appropriate systems and processes for assessing and monitoring the quality of the service. The provider did not have sufficient systems and processes to mitigate the risks relating to the health, safety and welfare of service users.