Next Step Support Limited

Next Step Support Limited

Inspection report

159A Chase Side
Enfield
Middlesex
EN2 0PW

Tel: 02083664552
Website: www.nextstepsupport.co.uk

Date of inspection visit:
30 January 2018
31 January 2018
02 February 2018

Date of publication:
03 April 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

This inspection took place on 30 and 31 January and 2 February 2018 and was announced. We gave the provider 48 hours' notice that we would be coming because we needed to be sure that someone would be available to support us with the inspection process.

Next Step Support Limited provides the regulated activity of personal care to people living in a supporting living accommodation setting. The service aims to support and rehabilitate people with enduring mental health conditions, learning disabilities and complex healthcare needs. At the time of this inspection there were 23 people receiving personal care.

At our last inspection we rated the service 'Good'. At this inspection we found the evidence continued to support the rating of 'Good' and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

.

At this inspection we found the service remained 'Good'.

The service continued to ensure that people received a safe service. Safeguarding policies and procedures were in place, understood and followed by all staff.

The provider followed safe recruitment processes to ensure all staff assessed as safe and competent were recruited by the service.

Risk assessments in place assessed people's identified risks and gave clear guidance on how to support the person with their identified risk in order to keep them safe.

Appropriate staffing levels were observed based on people's support needs and requirements.

People received their medicines safely and as prescribed. Polices in place supported these processes.

All accidents and incidents were recorded, monitored and analysed so that learning and further improvements could be implemented.

All care staff received the required training to support them in their role. Staff told us and records confirmed that they were appropriately supported in their role through training, supervision and annual appraisals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's needs were assessed prior to admission to the service to ensure that they were able to meet

people's individual needs, choices and preferences. Detailed and person centred care plans provided clear information on how people wished to be supported.

People chose what they wanted eat and planned their own menus for the week. People decided the level of their own involvement with the preparation of their meal and where they required support. People had access to a variety of healthcare professionals and were supported by care staff where needed.

We observed people had established caring relationships with the staff and managers at the schemes. Care staff spoke with people with respect and promoted their independence. People were involved in all aspects of the care and support that they received especially through regular review meetings.

Complaints received were recorded and investigated according to the provider's complaints policy. People and relatives knew who to complain to if they had any concerns to raise.

A clear management structure was in place which allowed oversight and monitoring of service provision at each of the supported living schemes where people were supported with the regulated activity of personal care. A number of systems were in use to ensure that continuous monitoring, learning and improvement of services was implemented.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Next Step Support Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 30, 31 January and 2 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service in a number of supported living schemes and we needed to ensure that the registered manager would be available to support with the inspection process.

Two adult social care inspectors carried out this inspection with the support of two experts by experience who made telephone calls and spoke with people and relatives of people using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We used 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.

The inspection process included visits to five supported living schemes, to meet people living at those schemes, staff working with people, and to check records kept at the schemes. We also carried out observations of people's interactions with staff and how they were supported, as some people were unable to communicate with us due to the complexity of their conditions.

During the inspection we spoke with eight people and one relative. We also spoke with the provider, the registered manager, the training manager, four service managers, one deputy service manager and ten care staff. Following the inspection on 31 January 2018 the experts by experience spoke with three relatives and

two people using the service. We looked at 11 care plans and seven staff and training records, medicines records and records relating to the management of the service such as audits, policies and procedures.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe when receiving personal care and support from care staff. One person said that they felt safe with carers and had no concerns. One relative stated, "I do think that my [relative] is safe, he doesn't go out on his own. My [relative] phones me every day, he always seems happy."

A safeguarding policy was available and had been re-written into an easy read format so that the policy was easily accessible and people and care staff could read and understand the processes to follow in order to safeguard people from abuse. The provider and registered manager held oversight of all safeguarding referrals and concerns that had been raised and were able to evidence the actions they had taken as a direct result.

Staff demonstrated an understanding of safeguarding practice and how to provide care for people at risk of exploitation and abuse. Care staff clearly explained the steps they would take if abuse was suspected. One care staff told us, "I have to protect the service user. I would tell the manager." Care staff understood the meaning of the term whistleblowing and were able to list external professionals that concerns could be reported to including CQC, the police and the local authority. All staff completed basic safeguarding training during their induction and this was updated annually.

People's identified risks related to their health and care needs had been individually assessed and documented. Clear guidelines were available on how people were to be supported with the risks in order to reduce or mitigate the risk to ensure people's safety. Identified risks included, smoking, use of the iron, use of drugs, destruction of property. All of the risk assessments we looked at had been updated at least every six months or more regularly when needs changed.

We observed sufficient staffing levels at the supported living schemes which had been determined based on people's support needs and requirements. Staff were usually assigned to one scheme to provide consistent care to people but were able to move between locations in the event of staff sickness or to cover holidays.

Staff files confirmed that the provider followed safe recruitment procedures. These procedures ensured that appropriate pre-employment checks were carried out including criminal record and identity checks and references confirming care staff performance in previous employment.

People received support with medicine administration where this was an identified need as part of receiving the regulated activity of personal care. All records pertaining to the safe administration of medicines had been appropriately completed. The provider completed daily medicine audits to ensure that any issues or discrepancies were identified and rectified immediately.

All care workers were trained in medicines management. However, the service had not carried out any medicine administration competency assessments to confirm and assess staff members understanding and competency in this area. The provider confirmed that competency assessments were to be implemented this year.

All accidents and incidents were recorded and analysed so that the care team could review and reflect in order to learn and improve service provision where required. We discussed lessons learnt and improvements with the provider and the registered manager who confirmed that bi-weekly meetings were held with all service managers to also review and analyse each incident with the focus on how to prevent or reduce such similar incidents from re-occurring.

Each person had a personalised personal emergency evacuation plan on their care plan which detailed how the person was to be safely supported in the event of an emergency. Checks had been completed of the serviceability of fire equipment such as the fire extinguishers and fire blankets in each person's flat.

The service ensured that staff understood infection control and how to protect people from infection. Staff had been trained in infection control and the service ensured adequate supplies of personal protective equipment such as gloves, aprons and shoe covers.

Good

Is the service effective?

Our findings

We asked people and relatives whether they believed care staff that supported them were adequately trained and skilled to carry out their role. Feedback from people included, "Yes, they are very good, I get on well with them" and "Yes, I do, I am comfortable with the carers, they are nice to me." Relatives told us, "From what I see they are knowledgeable his key worker is exceptional and the carers seem pretty good on hygiene" and "They [care staff] seem highly trained and naturally very nice people."

Care staff told us and records confirmed that each of them received an in-depth induction as well as training in a variety of topics including safeguarding, medicine administration, mental health awareness, epilepsy awareness and health and safety. We spoke with a new member of staff who said they had completed a comprehensive two-week induction programme. They told us this was enough time to become confident in their new role but that the manager had been happy to extend it if needed.

At the last inspection we found that the service had not completed any appraisals for care staff who had been in employment for at least one year. During this inspection we found that this issue had been addressed. Care staff told us that they were regularly supported through supervision and appraisals. Records seen confirmed this.

The provider ensured that pre-admission assessments were completed prior to admission to a scheme to ensure that people's health, care and support needs, choices and preferences could be met appropriately by the service. A person centred care plan was then compiled giving care staff information about the person and how they wished to be supported. Care staff reviewed care plans annually or sooner where a person's needs had changed or when the multidisciplinary team identified additional needs.

The service was regulated to provide personal care. However, care staff supported people with nutrition and hydration needs where this was an identified need. Staff completed food and fluid monitoring charts where specific concerns were noted in relation to a person's food and fluid intake or when instructed to do so by GPs. This demonstrated proactive working with other members of the multidisciplinary community team in order to ensure people were appropriately supported with their nutrition and hydration needs.

Care Staff teams at each scheme worked together to ensure that people received effective care and support. This included a detailed handover twice daily, daily logs of significant events as well as a detailed record of the personal care offered and delivered to each person. We also saw records of correspondence between a variety of external organisations such as social workers, out of hours crisis team, day services and colleges where people's assessed needs required the necessary input from these organisation in order to meet those needs.

Each scheme had established links with a variety of healthcare professionals including GP's, dentist, chiropodist, optician and district nurses. Each person had a record of when the service had referred them to the required healthcare professional, when they were seen and the outcome of the visit. The provider ensured that care staff were available to support people to attend appointments where required.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS.

Care staff demonstrated good knowledge of the MCA and of each person's mental capacity and ability to cope with decisions. For example staff gently guided people with mental capacity who were likely to make unwise decisions but respected their right to do this and did not intervene inappropriately. People had signed their care plans confirming that they had consented to their care and support package.

Good

Is the service caring?

Our findings

People that we spoke with were enthusiastic and very complimentary about the care they received and their experience of the service. One person said, "Everyone here is amazing. Beautiful and amazing. It's been the best time ever to come and live here." One relative we spoke with was highly complementary of the service. They said, "[Relative] moved here when they needed more help than I could give them at home. I was really worried about it but I shouldn't have been. The staff are wonderful, you couldn't ask for any better." People and relatives confirmed that care staff always treated them and their relative with dignity and respect and that they had built compassionate and meaningful relationships.

We further confirmed this during our observations of interactions between staff and people. For example one person was concerned they had not been able to clean their oven to the standard they wanted. The location manager said they would send a care worker to show them how to use specific cleaning products and how to clean kitchen equipment to the way they wanted. Another person told us staff helped them to develop ways to express their feelings in ways other than shouting and talking, including through art.

Staff involved people in all aspects of their care. We saw evidence of this from our observations of care, discussions with people and staff and from reviewing care records. For example, staff asked people how often they wanted to be shaved and taken to the barber shop or hairdressers. In addition they asked people how they wished to receive their personal care such as if they preferred a shower or bath. Relatives also confirmed that they were involved in their relatives care and support planning and that care staff and scheme manages always kept them abreast of any changes or new developments in their relatives care needs.

Care staff knew the people they supported well and were very aware of their likes, dislikes, preferences and choices as well as their personalities and behavioural traits. With this knowledge care staff knew how to support people in a way which took into account their mental health needs and disabilities and supported them to maintain positive well-being.

People and relatives confirmed that care staff were always respectful of their privacy and dignity. One relative told us, "They are respectful of his privacy when I have been there they always knock on the door." All of the care workers we spoke with demonstrated a detailed understanding of the principles of privacy and dignity and could give examples of how they adhered to these. We also saw evidence of this during our observations and from speaking with people.

People living at the schemes were supported by care staff in a way which promoted their independence. People held their own tenancy agreements and were responsible for maintaining certain aspects of their own care and housekeeping where possible. Care staff understood the importance of promoting people's independence.

Good

Is the service responsive?

Our findings

Care plans and records were detailed and reflected each person's individual care needs. People's likes and dislikes, choices and preference had been clearly recorded such as if they preferred a male or female care worker.

People's personal history had been documented to enable care staff to provide personal care in a way which met people's specific needs and requirements. Care plans included information about each person's culture, relationships, sexual health needs and friendships and the context about why they were vulnerable or needed support.

Each person was allocated a named key worker, who they knew and who was responsible for reviewing the persons care plan and risk assessments as well as reviewing their set goals and targets in relation to their health and social care needs. The key worker met with the person on a fortnightly basis to review their care and support needs and a monthly progress report was produced and shared with the care staff team. Several people were engaged in academic or vocational courses and staff helped them with routine, organisation and time to study.

People told us they were treated as individuals and felt staff went out of their way to make sure they had the kind of life important to them. For example one person said, "This place has literally turned my life around. I was a mess before. These people [staff] are my family and I'm sad I have to leave them soon but I always wanted to be independent again and I will be soon. I'm cooking, cleaning, working, all the stuff I should've been doing anyway. There is nothing they could do differently; I wouldn't be here if it wasn't for them."

Staff monitored the outcomes of people who they provided care to. For example, one person had a significant history of inpatient hospital stays related to mental health. However they had not experienced any hospital admissions in the two years since joining the service and had been discharged from social psychiatric support. We asked a senior member of staff about this. They said, "We work with people on a very individual level. We get to know them and provide guidance and encouragement but strongly prioritise their independence. When we do this their mental health improves and they become happier and improve their functioning."

Staff adapted services and resources to the individual needs of people. For example, one person was not able to understand or communicate in English. To enable staff to communicate with them and make sure they delivered individualised care, a pictorial communication chart had been developed. We saw this is in use and found the person responded positively. The service had also supported staff to learn different languages and communications methods such as British Sign Language in order to respond to people's individual needs.

Service managers demonstrated a commitment to developing their services or accessing a variety of external services based on individual needs so that people were always engaged and involved in living a full and sociable life. For example one manager had planned and implemented an extension of the building

after observing how sociable people were, which meant they would benefit from more communal space. Other examples we saw included service managers accessing a variety of community services including chess clubs, the deaf association, mental health support groups and confidence workshops. One service manager told us, "My ultimate aim is to come and find an empty scheme where everyone is out and engaged in an activity."

People and relatives knew who to speak with if they had any complaints or issues and were confident that these would be appropriately addressed. One relative stated, "[Registered manager] is fine and I can always talk to him. Any concern would be taken seriously." Complaints received were documented with details of the complaint, the action taken, the outcome of the complaint and any recommendations or learning that could be taken from the complaint.

Good

Is the service well-led?

Our findings

A registered manager was in post. 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 and relatives gave positive feedback particularly about the service managers and key workers immediately involved in their care or the care of their relative. People and relatives also knew the registered manager and the provider and told us that they were approachable at any time.

Staff spoke positively about service managers allocated to each supported living scheme. Staff described good working relationships and working culture. One care worker said, "Everyone is very considerate towards each other. Nobody needs prompting or encouraging and we all support each other."

Care staff also confirmed that they were supported in their roles through various processes including team meetings, daily handovers, supervision and training. One care staff told us, "Some staff meetings are planned some are ad-hoc. We share skills, learn and improve. It's about combining wisdom with knowledge."

Service managers were responsible for ensuring staff remained up to date with policies in the organisation including when they changed or were updated. All of the care workers we spoke with said they felt well informed of policies and knew how to access them.

The provider, registered manager and service managers carried out a number of audits and checks to monitor the quality of care provided with a view to learning and improving. This included medicine audits, personal care spot checks, key worker audits, care plan audits, environmental and health and safety checks. One care worker said, "The [registered manager] and the director often come and do spot checks. It's a very helpful process because we get to see our service from someone else's eyes to make sure we're doing a good job."

Most recently the provider had commissioned an external agency to carry out an overall mock CQC style inspection of the entire service where the regulated activity of personal care was provided. Where issues had been identified an action plan had been devised so that the service could learn and make the required improvements to the quality of care being delivered.

In all locations we visited the allocated service manager operated an open-door policy for people and staff who lived and worked there. This was a deliberate strategy to help people feel comfortable and relaxed in their home and to ensure it did not feel clinical. Staff had a private space to use for quiet conversations and the overall approach meant people felt empowered as individuals.

People and relatives confirmed that they had been asked to complete satisfaction surveys and comment on

the quality of the care and support that they received. Completed surveys seen were positive.

People were also involved in the staff recruitment process. We spoke with the person who joined the panel and the member of staff they helped to interview. The person told us, "It was really important to know they'd be good at looking after all of us. Especially when I have bad days and can be very challenging." The member of staff said, "This really attracted me to the company – that they placed enough importance on people that they could help recruit new people."

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals such as social workers, mental health clinics, well-being services, crisis services, sexual health clinics, counselling, drug rehabilitation services. Most recently the service had commissioned the services of an in-house psychologist which people had access to where this was an identified need.