

**We are the regulator:** Our job is to check whether hospitals, care homes and care services are meeting essential standards.

## Supported Housing

94 Mill Lane, Beverley, HU17 9DH

Tel: 01482867283

Date of Inspection: 18 June 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

<b>Consent to care and treatment</b>	✓ Met this standard
<b>Care and welfare of people who use services</b>	✓ Met this standard
<b>Staffing</b>	✓ Met this standard
<b>Supporting workers</b>	✓ Met this standard
<b>Assessing and monitoring the quality of service provision</b>	✓ Met this standard
<b>Complaints</b>	✓ Met this standard

## Details about this location

Registered Provider	East Riding of Yorkshire Council
Registered Manager	Mrs. Rosemary Parvin
Overview of the service	<p>The East Riding of Yorkshire Council's (ERYC) Supported Housing service provides 24 hour domiciliary care and support to 40-50 people with learning disabilities in the community. It has an office base in Beverley. Support workers provide a service to people living in either supported living scheme properties or in private properties. Hours of operation are dependent upon individual needs and parts of the service operate over 24 hours, providing sleep-in support as required.</p>
Type of service	Domiciliary care service
Regulated activity	Personal care

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

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## Summary of this inspection

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### Why we carried out this inspection

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This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 June 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

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### What people told us and what we found

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We used a number of different methods to help us understand the experiences of people who used the service. During the day we visited people in their own home and talked with them about their experiences of the service. We also observed their interactions with staff. We spoke with the manager and three members of staff. We reviewed documentation including five care plans.

We saw that care needs were discussed with people and/or their relatives and before people received care their consent was asked for. One person said "They ask me what I like".

People told us they were well cared for. One person said "The staff are good. We had a trip to the Humber Bridge with a worker yesterday". Another person told us "I get to do what I want".

There was enough qualified, skilled and experienced staff to meet people's needs. Staff had received appropriate professional development and training to ensure they could meet the needs of the people who used the service.

There was a complaints procedure in place at the home. The people we spoke with knew what to do if they had any concerns. The provider had systems in place to assess and monitor the quality of service that people received.

You can see our judgements on the front page of this report.

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### More information about the provider

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Please see our website [www.cqc.org.uk](http://www.cqc.org.uk) for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

### Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

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### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

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### Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We spoke with six people who used the service, the manager and three members of staff. We looked at five care files to see whether decisions about consent to care had been recorded and were acted upon. We also checked to see whether people who used the service signed documentation held about them or whether their relatives or representatives signed the documentation on their behalf.

We saw that each care file contained some information on a person's capacity to make decisions and what decisions had been made. The information was within the Local Authority's support plan. Examples included "X has capacity. X is able to make their own thoughts and wishes known" and "X has capacity and has a good memory". Some of the recorded decisions and support plans were signed by people who used the service. We saw the annual reviews of these plans included a section that covered consent, mental capacity and Deprivation of Liberty Safeguards (DOLS). The provider may wish to note that in most of the reviews this section had not been completed. Staff may not have known if these areas had been reviewed and consequently whether a person's ability to make decisions and give consent had changed.

The manager told us that when necessary, she would hold a best interest meeting to discuss a person's care and treatment. Best interest meetings take place when informed choice cannot be made by the individual, and includes the views of all those involved in the individual's care. We were told there had been no recent best interest meetings held. We saw in one file that the possible need for one had been discussed about dental treatment but had subsequently not been required.

We saw staff interacting with people and offering them support and we saw staff give time for people to consent to this support. We saw one person being asked if they would like to help to set the table. The person told us it was usually his job to set the table. The

manager and staff we spoke with gave examples of how they gained a person's consent which was based on the information we saw in the care files. One person we spoke with said "I decide what I want to do. My key worker helps me". Another person said "We choose the menus together and then we go shopping".

Where appropriate we saw it had been recorded if anybody had been appointed to make decisions on behalf of a person using the service. We saw in one care file that a deputy had been appointed by the Court of Protection regarding a person's finances. The Court of Protection is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints deputies to make decisions in the best interests of those who lack capacity to do so.

The service had policies in place about consent and the Mental Capacity Act 2005 (MCA). Staff had an awareness of the MCA and Deprivation of Liberty Safeguards (DOLS), and some staff told us it was part of their training programme. We saw that nine staff (out of seventeen) had received training about the MCA. The manager told us she was awaiting further dates for training as the provider was currently reviewing its training programme for these areas.

**People should get safe and appropriate care that meets their needs and supports their rights**

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**Our judgement**

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The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

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**Reasons for our judgement**

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People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We spoke with six people who used the service, the manager and three members of staff. We reviewed documentation including five people's care files, two for people requiring 24 hour support.

Each person had a care file. The care files included personal information, needs assessments, risk assessments, individualised support plans, diary sheets and reviews of plans. Most care files also had a photograph of the person concerned which helped staff to identify the correct person when providing care.

We saw there was more personal information in the two files we looked at for people requiring 24 hour support. These files had a profile of the person called "This is about me" which was comprehensive and in an easy to read format. For example sections included "Things important to me" and "How I like to spend my time". In one file there was a "Speech communication sheet" to help staff understand what the person was saying, for example "Beeki" meant "Biscuit". There was also more information in these files about a person's life history which helped staff to understand the person better and provide appropriate care.

Needs assessments and risk assessments were personalised and covered a wide range of areas dependent on people's needs. We saw assessments covering personal care, physical wellbeing, medication, social interests and others. The risk assessments clearly identified what each risk was, an assessment of the risk, management of the risk and any comments. These assessments were developed into support plans. The support plans included sections on "About You", "Details of care and support", "What you can do for yourself and what you need support with" and "Social activities." The plan explained what care was required and by whom.

In the files we looked at there were also copies of the Local Authority's annual reviews of support which included comments by both the person using the service and where appropriate their relatives. For example X said "I feel very happy with the service and feel



it meets my needs".

The two files we reviewed for people who received 24 hour support contained separate sheets recording appointments and interactions with health professionals including GPs, opticians and dentists. Staff told us that these consultations and visits helped them care for people and ensured they had the benefit of expert advice and knowledge. In the other three files there were entries about health professionals input in the diary sheets but no specific section. The provider may wish to note that for these people staff could not easily monitor input from other professionals. As a consequence staff may not have been able to fully support people to receive the care they required.

We saw and were told by staff and people who used the service that housing placements had been found to match people's needs and personalities. People appeared happy in their homes. One person said "I came to the house because of the garden. I enjoy sitting in the garden".

During a period of observation we noted that all staff interactions with the people who used the service were positive, polite and encouraging. We saw that people were encouraged to be independent. Staff spent time talking to people and helping them make choices. We were told by people who used the service that they were offered a variety of activities which included going out shopping, trips, access to a local day centre, holidays and others. People joined in with these activities and their engagement was positive. One person said they were planning this year's holiday and "We went to Bridlington in a caravan last year which I enjoyed".

We saw that the service had procedures in place for dealing with emergencies including accident and incident reporting systems and contingency plans for when there were unexpected events and demands on the service. There was a 24 hour emergency telephone contact service that people who used the service or their carers could ring. Then, if a visit was required it was arranged through the service's emergency duty team.

## Staffing

✓ Met this standard

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

### Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

### Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

The staffing levels on the day we visited were good. We noted that staff were a visible presence and were attentive and available for people in their homes. People who used the service told us staff were good. One person said "The staff are good, they help me get dressed" and another person said "I get on well with the staff; it's always the same staff".

The manager explained how the staffing levels, experience and skill set were based on the needs of the people who used the service and the level of referrals. There were 17 permanent staff members on the rota which included the day and night staff. There were two rotas, one for the 24hour care service which included sleeping cover for three houses and the other for the "Floating" care staff.

We looked at the current and previous staff rotas and found the staff numbers were consistent through the weeks. There was usually three to four floating care staff on duty and one staff member per house on the day time shifts. We noted that staff from the Council's bank of care staff had been used on a weekly basis, usually for two to seven shifts per week. The manager told us the service was holding vacancies because the service was undergoing a review. She assured us that to maintain continuity of care for the people who used the service the same bank staff were regularly used. This was evidenced from the names on the rotas and confirmed by the staff we spoke with who said that the bank staff used in the service knew the people well. One member of staff said "It's difficult to get new staff as the service is under review and is not appointing to permanent posts". We were told some recruitment had occurred last year but the post holders had temporary contracts.

The service was able to respond to unexpected changes for example sickness. The manager and staff told us that most annual leave or sickness was covered by existing staff, who worked part time, doing extra hours or bank staff. The manager said they did not use external agency workers. Staff confirmed external agency staff were not used.

The service used the East Riding of Yorkshire Council's procedures for maintaining staffing levels, for example, managing sickness and recruitment policies.

**Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

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## **Our judgement**

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The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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## **Reasons for our judgement**

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Staff received appropriate professional development.

Staff training records and records of staff supervision were reviewed and discussed with the manager and two members of staff. There were training and induction policies in place. The manager told us that training needs were identified and reviewed through the East Riding of Yorkshire Council's Employee Development Reviews (EDRs). The provider had a training department that ran courses based on the information collated from the EDRs. This helped ensure that staff had the training necessary to provide appropriate care for the people who used the service.

We were told by the manager that there was an expectation that staff completed the following training sessions as part of mandatory training: first aid, health and safety, safeguarding, infection control, basic food hygiene, needs and risk assessment, learning disability and managing challenging behaviours. We saw from the training matrix and the training certificates held in staff files that the majority of staff had completed these sessions. Staff said that the training had helped them to understand the care needs of the people who used the service. The provider may wish to note that very few staff had completed any recent training for learning disability apart from a course about autism. Staff may not have had adequate knowledge to provide the care required for the people using the service.

There was an induction policy in place for new staff which was based on national good practice "Skills for Care". Staff we spoke with told us that the training was good. Comments included: "We do a lot of training" and "We do the mandatory courses and others that were useful for the job, for example person centre planning".

The manager told us that staff had EDRs and appraisals twice a year. This was corroborated by what staff told us. Staff said that the management support was good and that they could raise issues. A comment included "There are good systems to automatically get put on the training". We saw evidence of staff meetings. Staff said they felt they could raise issues for discussion at the meetings.

## Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

### Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

### Reasons for our judgement

People who used the service, their relatives and staff were asked for their views about their care and treatment and they were acted on.

The manager told us how they regularly assessed and monitored the quality of care and treatment that people received. We saw evidence of a number of different ways that quality of care was checked and improved including reviews of care plans, tenants' meetings and surveys of people who used the service, staff and stakeholders.

Risks were appropriately identified, assessed and managed. Care plans contained evidence that they were reviewed on a regular basis and following any incidents. Risk assessment for both people using the service and staff were reviewed, for example, lone working risk assessments for staff.

Health care professionals had been involved in a person's care, including GP's, dieticians, and district nurses. In the care plans we looked at we saw that changes in a person's care needs or advice given by health care professionals had been included.

We saw there was a yearly plan to consult with people who used the service, family and friends, staff and stakeholders and that action plans were in place to improve services based on feedback received. We saw from the responses in the most recent survey of people who used the service and stakeholders that they thought the support was good. We also saw that the results of the surveys were collated and fed back to people in an easy to read format. One comment was "We will make sure we always arrive on time".

There were effective systems in place to respond to complaints (see next section) and compliments, for example "Thanks to the Bridlington team for supporting X to move to a new flat.

The provider held meetings to disseminate information and best practice to managers of services. The manager told us that she ensured the staff were kept up to date with the latest guidance. Staff told us that staff meetings had taken place on a regular basis and that they had received regular supervision. We saw minutes of the last three staff

meetings. Items for discussion included improving care for people, staffing levels and effective handovers as staff changed shift. Staff felt that their views and concerns were listened to and acted upon. A staff member said "Managers are open to ideas and we have staff meetings where ideas are discussed".

**People should have their complaints listened to and acted on properly**

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**Our judgement**

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The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

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**Reasons for our judgement**

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People were made aware of the complaints system. This was provided in a format that met their needs.

We reviewed documentation and spoke with three people who used the service and the manager about the complaints procedure.

People who used the service were provided with information in the Service User Guide which was given to everyone when they started with the service. The complaints procedure was referenced in the guide and an easy to read version with pictures was attached to the back of the guide. The complaints information clearly stated who to contact and what the procedure was. There was a complaints policy and procedure in place that was developed and reviewed by the provider.

The manager informed us that the service had access to an advocacy service should it be required.

We saw the compliments and complaints log which indicated that there had been three complaints in the last 12 months. The nature of the complaints were clearly recorded together with the date they were received, the date acknowledged, who dealt with them, what the outcomes were and when the matters were closed. We saw that actions and outcomes were communicated to staff either individually or within staff meetings so learning could take place.

When we spoke with people who used the service they indicated they would talk to their key worker if they had any concerns. They also knew the manager of the service and said they would talk to her as well.

We also noted there was a service user satisfaction survey completed by the person with their care co-ordinator at the end of every annual review. We noted in one file that the survey said "X was satisfied with his care, no concerns".

The manager and staff said they tried to treat everyone in a respectful manner. They felt this relaxed approach enabled them to discuss any minor issues with people before they reached the level of complaint.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.


In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.


You can tell us about your experience of this provider on our website.


## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

 **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

 **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

 **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.



## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

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**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

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**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

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We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

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### **(Registered) Provider**

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There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

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### **Regulations**

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We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

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### **Responsive inspection**

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This is carried out at any time in relation to identified concerns.

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### **Routine inspection**

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This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

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### **Themed inspection**

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This is targeted to look at specific standards, sectors or types of care.

## Contact us

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