Stars Social Support Limited

Stars Social Support

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?	Requires Improvement

Summary of findings

Overall summary

This was an announced inspection which took place on the 31 October 2016. The service was last inspected in August 2013 and was compliant with the regulations in force at that time.

Stars Domiciliary care agency provides support to children and adults with disabilities who live in their own homes. The service was supporting 59 people at time of inspection.

The service had a registered manager 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.

We found that people's care was delivered safely and in a manner of their or their representatives, choosing. People were supported in a way that reflected their wishes and assisted them to remain as independent as possible. Staff were aware of signs of potential safeguarding issues and knew how to raise them both internally and externally.

Staff were well trained and encouraged to look for new ways to improve their work. Staff felt valued by the registered manager and this was reflected in the way they talked about the service, the registered manager and other staff. Staff were not receiving regular formal supervision but the registered manager had put in place steps to address this with staff. Staff had access to informal and ad hoc supervision and told us they felt supported.

People who used the service were initially assessed and then matched up with suitably trained staff to support their needs, and if people requested changes to how support was delivered these were facilitated quickly. People and relatives were complimentary of the service, and felt included and involved by the staff and registered manager. Where people had specific needs, staff attended training before starting work with them to ensure they had the correct skills and competencies in place. We saw that staff had access to very comprehensive induction training.

The service had not always formally sought and confirmed people, or their representatives, consent when assessing and devising their care. People and relatives we spoke with told us that staff sought their consent verbally before delivering any care. From talking to staff and checking other care records we could see that the best interests' decision making process had been followed, but that the provider's records did not support the clear recording of the process and final agreement.

There were high levels of contact between the office and senior staff and people with those staff seeking feedback and offering support as people's needs changed. People and their relatives were able to raise any questions or concerns with the service and were confident these would be acted upon. No one we spoke with had any issues or complaints about the service they received.

Staff worked to keep people involved in their local community and in activities that mattered to them where possible. Relatives thought that staff were caring and supportive and sought their advice and support with the permission of the person.

The service had not always identified and acted promptly upon issues such as the failure to regularly supervise staff, to ensure that consent was correctly recorded and record keeping of the use of best interest's decision making was in place.

The registered manager was seen as an experienced leader by staff, people using the service and peoples relatives. The registered manager was trusted and had created a strong sense of commitment to meeting people's diverse needs, supporting their staff and developing a better service. The registered manager had recently taken steps to increase management support and to develop and IT solution to help reduce paperwork and improve their ability to collate and analyse quality data.

We found a breach of regulation in relation to good governance. You can see the actions we have asked the provider to take at the end 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?

Good

The service was safe.

Staff knew how to work to keep people safe and prevent potential harm from occurring. The staff were confident they could raise any concerns about potential abuse or harm, and that these would be addressed to ensure people were protected from harm. People in the service felt safe and able to raise any queries they may have.

Recruitment records demonstrated systems were in place to ensure staff were suitable to work with vulnerable people.

Staff were trained and their competency checked to make sure people received their medicines.

Is the service effective?

Good

The service was effective.

Staff received support to ensure they carried out their role effectively. Supervision and appraisal processes were not in place to for all staff; the registered manager had taken steps to address this.

Arrangements were in place to request support from health and social care services to help keep people well.

Staff had a basic awareness and knowledge of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where they did not have capacity. Formal consent had not always been sought or confirmed in records kept.

Is the service caring?

Good

The service was caring.

People and family members told us staff were very caring, respectful and friendly.

Staff were aware of people's individual needs, backgrounds and

personalities. This helped staff provide individualised care for the person.

People were helped to make choices for themselves and to be involved in daily decision making wherever possible.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and staff were trained and supported to work with people in a caring and sensitive manner. The care records showed that changes were made in response to requests from people using the service and changes over time.

People could raise any concerns and felt confident these would be addressed promptly. No one we spoke with had any concerns about the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had not responded quickly to the failure to supervise staff. The services audits and checks had not identified the issue of failing to seek and confirm consent or that decisions made in peoples best interests had been recorded correctly.

A registered manager was in place who encouraged an ethos of empowerment and compassion amongst staff and people who used the service.

Staff said they felt well supported and were aware of how to contact the registered manager or on call for support throughout the day.

The registered manager monitored the quality of the service and looked for any improvements to ensure that people received safe care.

Stars Social Support

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 inspection took place on the 31 October 2016 and was announced. We gave the service 48 hours' notice as it is a domiciliary service and we needed to be sure staff would be available. The visit was undertaken by an adult social care inspector who visited the services office on 31 October and made further telephone calls to people, relatives and external professionals after to gather further feedback.

Before the inspection the provider completed a Provider 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 they plan to make. We also reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before inspection we contacted commissioners of the service for feedback. We planned the inspection using this information.

During the inspection we spoke with four staff including the registered manager. We spoke with three people who used the service and two relatives as well as one external professional who had regular contact with the service.

Six care records were reviewed as was the staff training programme. We also reviewed seven staff recruitment files, supervision, induction and training files, and staff meeting minutes. The registered manager's quality assurance process was discussed with them.

Good

Is the service safe?

Our findings

People and relatives told us they felt the service they received helped to keep them safe and considerate of their safety. One person told us, "I have the same carers and they know what I can do and when I need help. I worry about security at night and the staff make sure I am secure before they leave". A relative also told us that staff looked for possible areas of risk to their relative. They told us the registered manager had assessed the home environment to see if there was any way to reduce risks in their relative's home, such as the access route to the house. They told us they hadn't expected all the other advice and emotional support that came with the service, and both they and their relative felt satisfied with the service to date. An external professional told us they had shared information about a possible risk with the service and they had taken steps to reduce those risks as soon as they started working with the person.

We asked staff about their safeguarding training and their knowledge as well as checking staff training. The service had worked with a person's social worker around an issue of vulnerability due to their disability and behaviour. They had formulated a clear care plan with the person which meant staff discreetly supported the person to stay safe. The staff told us they were clear how they supported the person to stay safe, whilst respecting and balancing their rights and choices to take risks. Staff told us how they would raise any concerns and what the process was to do so, and they all felt confident the registered manager would take prompt action.

The registered manager told us they reviewed incident records after each event as well as monthly, looking for ways to reduce future likelihood of events occurring. The registered manager showed us how the process they used to assess each person prior to commencing any service, creating an initial care plan alongside the person, any relatives and external professionals. This identified any risks in the person's home environment or that may occur as a result of delivering care, for example moving and handling whilst providing personal care. At this point they would check to see if any aids or adaptations could assist the person to reduce any risks and create an initial care plan.

Staff told us they were able and encouraged to raise any concerns they had about the service or their work. They told us the registered manager was open to comments and suggestions, and they knew how to contact external organisations to raise any concerns, or 'whistleblow' (report poor practice), if necessary. Staff had attended relevant training to support this, and in the registered office and on the provider's web site we saw that staff had information about organisations they could approach if they had concerns. On the providers web site we saw that the services 'open door' policy was highlighted and that feedback was encouraged.

The registered manager told us how they assessed for staffing requirements when initially assessing people and that most care was one to one. However where risks were identified then additional staffing was available to meet people's needs, for example with moving and handling if two staff were required. People and relatives we spoke with told us that staff knew how to support them and had been introduced to them beforehand and they sometimes shadowed experienced staff. One staff member told us, "I supported someone to go out of the home, but I had to have special training on medicines first as they had 'as and when required' medicines I may need to use whilst in the community". They told us there was a specific care

plan in place for this and they had to read and check they understood this before starting work with this person.

We looked at personnel files to make sure staff had been appropriately recruited. Relevant references and a result from the Disclosure and Barring Service (DBS) had been sought. A DBS checks if people have any criminal convictions or are barred from working with vulnerable people. We saw that these DBS checks had been obtained before applicants were offered their job. Application forms included full employment histories and we saw that previous employer or character references had been checked. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Staff told us and training records confirmed they were trained to both prompt and administer medicines to people they supported. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed annually. Staff said they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. Staff competency was observed three times before they were able to work alone. Suitable checks were made and support put in place to ensure the safety of people who managed their own medicines. The process for auditing and checking medicines administration records had not always identified what actions had been taken where issues arose. We discussed this at inspection and after inspection the provider sent us information which showed what actions had been taken and how they would ensure the process of review, learning and action was more clearly recorded in future.

Staff had completed infection control training as part of their induction and told us that protective equipment, such as gloves and aprons were available as needed. Office staff told us that when they made calls to people they would check and top up supplies if required.

Good

Is the service effective?

Our findings

People, relatives and an external professional told us the service offered was effective at providing suitable staff to meet people's needs. One person told us, "I am very happy with STARS staff. They turn up on time, and I get the familiar faces I like. They are always keen to start and seem happy in their day." An external professional told us, "The staff they recruit seem to be very down to earth, but keen to support people they way they ask to be supported." Feedback the service had via compliments demonstrated that people felt the service was meeting their needs, as well as advising them how to access other services. These other services might be from another part of the provider group, as well as other community based services.

The staff we spoke with told us they had undertaken all necessary training to help them meet the needs of the people they supported. This included obtaining extensive training in medicines management; dementia care; equality and diversity; health and safety; and courses in safe working practices such as lone working. Staff told us the training they received was relevant to their roles in a community setting, supporting people in their own homes to live independent lives. The registered manager had a process in place to ensure that staff attended regular refresher training and updates. Staff had also been provided with one off specialist training for specific people's needs. Examples included tracheotomy care and the use of emergency medicines such as buccal midazolam and rectal diazepam.

We looked at how new staff induction training was organised. We saw that staff undertook Skills for Care Common Induction standards or Care Certificate induction training and this was checked by senior staff and at supervision. Staff told us the training was reinforced by staff being observed in practice as well as discussions amongst the staff team. The registered manager said any new staff member shadowed experienced staff before working alone.

Records of staff supervision did not demonstrate that staff were receiving supervision and appraisal as regularly as the providers policy stated. The registered manager was open that this was an issue affecting the service and had already taken steps to ensure that supervisions were arranged and taking place. We saw this included writing formally to staff who did not attend booked supervisions. The registered manager agreed to ensure that supervisions would be occurring in line with their policy and was exploring other ways to support staff alongside formal supervision sessions. Staff we spoke with told us they could contact the registered manager, senior or office staff for support as required, and they had a quick response to any queries they may raise.

People told us the staff kept them up to date with any changes to their service, and the registered manager told us they talked to staff and people regularly to ensure that any concerns or issues were picked up promptly. A survey of people in 2015 showed people were happy with the information they received from the service.

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. CQC monitors the operation of the Mental Capacity Act 2005.

We saw that people's consent had been sought by staff as a part of the initial assessment process. However this was not always clearly recorded in copies of care plans or records in the provider's office. People and relatives we spoke with told us that staff had sought their consent and asked permission before carrying out any care tasks and confirmed this was a recording issue. Where care was provided to children the relevant persons consent was not always recorded in records so it was unclear that formal consent had been given.

Where someone was unable to consent, as they lacked the capacity to do so, the records did not always demonstrate the process by which consent had been sought. From talking to staff and checking other care records we could see that the best interests' decision making process had been followed, but that the provider's records did not support the clear recording of the process and final agreement. We discussed this recording error with the registered manager who agreed to ensure that records kept demonstrated that consent had been given.

Peoples care plans included care around helping people to eat and drink to maintain their health and wellbeing. We saw that peoples support needs around eating and drinking had been assessed and for some people a specific care plan had been created. Some people were involved in meal preparation and required different levels of support. They received support from staff to help prepare or make a meal and drinks. People's records showed the support they required. For example, a care plan stated, "[Name] can help to make simple snacks for themselves and cut up vegetables for meals."

We saw from the written records the service regularly involved other health and social care professionals in people's care. This included social workers, district nurses, behavioural specialists and GP's. We found evidence in records that staff quickly escalated people's physical or mental health problems to the appropriate specialists. Office staff we spoke with told us how they often liaised with external healthcare professionals on behalf of peoples care staff so that carers could focus on meeting people's needs.

Good

Is the service caring?

Our findings

People and their relatives told us the service offered was caring towards people. For example one person told us how the staff had supported them during a difficult period for their family carer. They told us how the staff had offered additional support, sought social services input and advice, as well as offering emotional support over a traumatic period. The person told us that the service was not asked or instructed to do this; they did this on their own initiative. Another person told us how staff had helped facilitate a short trip away from home for them. They had helped them source suitable transport and advised them of the potential costs and sources of funding for this. Again they told us this had not been requested but suggested to them by the services staff.

The registered manager and staff understood people's individual needs and told us how they supported them to retain and regain control over their life. Staff completed initial care plans to help describe people's preferences in their daily lives, and important details about their previous lives, hobbies and interests. This helped staff to be able to provide support in an individualised way that reflected people's wishes. Staff we spoke with knew the details of people's past histories and their personalities and had been able to get to know them. We saw that care plans had been adjusted as people's preferences and experiences changed over time or as they developed new interests. For example staff told us how they assisted people with managing of their finances to save for upcoming events. One family was supported with their disabled child and this assisted them to continue to enjoy family life as well as have the child's needs met.

We saw the service had policies and procedures in place that referred to upholding people's privacy and dignity. In addition the service had policies in place relating to equality, this helped to ensure people were not discriminated against. Staff had read these policies as part of induction or when they were brought into place by the provider. We saw in care plan records and meeting notes where people's individual choices had been supported and advocated for by the service.

The staff we spoke with demonstrated a caring approach which they balanced with promoting and enabling the person's choices and independence. They told us they placed an emphasis on involving the person in decisions about their care, and in doing things with, and not for, the person. For example we saw that care plans showed how best to support a person, whilst identifying what tasks they could complete with prompting and guidance rather than direct support. This meant people were not further disabled by the staff's interventions.

When people were first assessed by the service they, and their families, were given information about the provider and who to contact if they had any concerns. Staff we spoke with told us that involving people, or their relatives, in care decisions assisted them in making the right choices for people. Staff told us that people were encouraged to continually express their views about their care and their preferences. This involved staff looking for non-verbal feedback, through changes to behaviour, where people were not always able to express themselves clearly.

The registered manager told us how staff were supported to maintain the values of the provider

organisation, of empowerment and respect to people. Staff we spoke with reflected these values back to us when we spoke with them, and in the way in which notes and records were updated. We saw that discussion about these values took place at team meetings and in supervisions and appraisal. For example where staff were reminded not to talk about other people and respecting confidentiality. Staff also told us how they ensured peoples confidentiality and privacy were respected, for example by seeking people's permission before sharing information about them with relatives.

From talking to staff and relatives we heard that the service endeavoured to respect people's privacy and dignity while providing care in their own homes. There were examples of how the staff had ensured people were able to spend time on their own or with family or friends, with staff withdrawing to afford them privacy.

Staff were aware of advocacy support that could be accessed to assist people with any conflicts or issues. We saw that people had been supported to access external support at critical times, such as advocacy or social work. The registered manager had information about these services in their office.

Good

Is the service responsive?

Our findings

People and relatives told us they felt the service was responsive to their changing needs. One relative told us that, "I had to make changes to the times we got support and they had no issues with sorting that out". A person using the service told us that "The carers are very good; they have got to know me well, and see me as my own man, not just a guy with a learning disability". Everyone we spoke with told us they felt the service offered was person centred and focused on doing their best for people.

People's care plans were personalised and based on discussion with them or their relatives, as appropriate. These were detailed and written in plain English. Staff we spoke with told us care plans were easy to use and formed the basis of their care to people. Initial care plans were drafted before any care commenced to assist in identifying suitably trained staff, and then amended with the person as their needs changed over time. Staff explained that plans were reviewed regularly, usually as needs changed over time but at least annually, but more often if people's needs changed. These reviews involved people, families and external professionals as required. Staff who had not worked with people for a while told us they had time to review care plans and speak to other staff to update themselves before starting work with a person again.

We checked the quality of care plans in the service. We found evidence that the service was creating clear and concise support plans that were easy to understand. Staff had written records of support provided that corresponded with people's plans of care. These records were checked by senior staff and any changes or updates to care plans made as a result. Care plans we saw detailed how people preferred to be supported and gave clear details to guide any new staff. For example one care plan detailed where staff should park so as not to block the person husband's car or neighbours, as this had been an issue. Another detailed how best to support someone to eat to avoid a choking risk as well as preserve their dignity.

People were supported with essential tasks of daily living, such as bathing, but also to look for occupation and leisure activity, such as trips or activities they could attend. People told us that staff supported them with suggestions and accepted their ideas, and that staff also accepted their choice when they declined.

People were supported to keep in contact with family and friends and staff told us how they often supported people by keeping family members updated on their lives. We saw from records and from talking to people that the service had made changes to people's care plans to accommodate family visits and important family events.

The registered manager told us how information about how to raise a complaint was made available to people at initial assessment. This was then part of any review or survey of people. The service had received two complaints in the last year. One did not relate to the regulated activity, the other led to a review of how one person was supported out of hours. Both had been responded to in line with the provider's policy and in a timely manner. Staff we spoke with told us that low level concerns were still brought to the registered manager's attention so they could intervene early and prevent formal complaints from developing. No one we spoke with had any complaints but felt able to raise any with the registered manager if they had any.

Requires Improvement

Is the service well-led?

Our findings

People and relatives we spoke with told us they felt the service was well led and met their needs in a manner of their choosing.

However the issues we found at inspection about the failure to regularly supervise staff, to ensure that consent was correctly recorded and record keeping of the use of best interest's decision making demonstrated that the service was not always well led. The issue of staff supervision had been identified, but management actions taken to date had not been effective in improving this situation meaning not all staff were being regularly supervised. We found that audits of care records had failed to identify that people, or their representatives, consent was not being correctly sought and recorded. Audits and reviews of care files had not also identified that contemporaneous records of decisions taken in relation to care and treatment were not being maintained by the service. We also found that the service was meeting the needs of one person without having the correct registration in place. We checked this persons care records and saw that suitable staff with the right skills and abilities were in place alongside the correct policies and procedures so this did not have any effect on the person using the service. Immediately after inspection the registered manager made an application to add the correct service user band to their registration.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, and relatives of people using the service told us the registered manager and other service staff regularly checked whether they were happy with their service. We saw that feedback was sought informally on a regular basis from all people and relatives, and this was positive, with positive comments about staff support and the registered manager. When we spoke with people and relatives about the management of the service they all made positive comments about the contact and support they received from the service and senior staff.

The registered manager told us they helped to keep staff positive through good support and training for them. They told us how this helped staff have the right skills to support people well and feel the positives of doing a good job. Staff we spoke with told us they felt the service offered a positive attitude to supporting people with complex needs. All the staff we spoke with felt able to raise any concerns with the registered manager or other office staff and felt confident they would be resolved.

The registered manager was present during our office visit and was able to get information requested quickly and was open and transparent with us throughout the inspection. They had identified that the issues relating to supervision, and were open to the comments made about recording of consent and recording best interests decisions where required. They had recently recruited an new staff member who would be supporting them in reviewing processes and procedures. The service was also developing a IT solution to a number of its paper based recording and audits processes. This was to help improve the registered manager's ability to check how well changes or improvements made to the service could be measured in future.

We checked the registered manager's knowledge of the legal requirements of a registered person, and that they had told us about incidents affecting the service in a prompt manner. We found in one record an incident where the police had been contacted by the service, but they had failed to notify the CQC. We discussed this with the registered manager who took immediate actions to ensure that if staff had contact with the police that a notification would be submitted promptly.

The registered manager had a process of regular audits of service quality, checking records when they came back from people's homes, for example medicines administration and care records. There were also checks via feedback from people and relatives. These took the form of calls from office staff, regular formal checks or reviews, and from meetings with a number of people who used the service. These involved people's relatives and external professionals as well when required.

The registered manager also met with staff regularly. They would hold the same meeting agenda at two or three meetings to ensure that all staff were afforded the time to attend a face to face meeting and contribute. Feedback was also sought via phone calls, home visits and an open door policy. Staff we spoke with told us they felt informed and updated by the service about any changes to their role.

The registered manager had also sought to support staff in a number of ways, for example by seeking the services of a financial advisor to offer free advice to staff. This could cover from debt to pension's advice. The registered manager told us that they would seek out ways to support staff with issues inside, and outside of work in order that they could reduce staff's stress. Staff we spoke with told us they felt the registered manager did care about their wellbeing and gave us examples of where the registered manager had been flexible or supportive.

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 17 HSCA RA Regulations 2014 Good governance The registered person had failed to maintain an accurate record in relation to decisions taken in relation to the care and treatment provided. The registered person had failed to maintain such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. The registered person had failed to evaluate and improve their practice in respect of the processing of the information referred to above. Regulation 17 (2) (c) (d) and (f)