Independent Lives (Disability)

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Inspection report

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18 February 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
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 the 16 and 18 February 2016 and it was announced.

Independent Lives (Disability) also known as 'Lend a Hand' is a charitable organisation. They are a domiciliary care service providing support to people in their own homes mainly between Littlehampton and Shoreham-by- sea in West Sussex. The service supports older people, people living with dementia, people with a physical disability, people with a learning disability, people with sensory impairments and people with mental health needs. At the time of our visit, they were supporting 92 people with personal care.

The service had a registered manager in post who had been registered since October 2013.
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.

Medicines were not always managed safely. The records in place did not demonstrate that people had received their medicines as prescribed. Staff administered medicines to people in their own homes in a personalised and professional manner, however significant gaps were noted in the records. This was fed back to the registered manager who had recognised this issue. During the inspection the registered manager told us about the new medicine system they would be introducing to drive improvements and minimise the risks to people.

People spoke positively about the support they received from the service and records reflected that there was sufficient staff to meet people's needs.

People told us that they felt the service provided a safe service. Staff understood local safeguarding procedures. They were able to speak about what action they would take if they had a concern or felt a person was at risk of abuse.

Staff felt confident with the support and guidance they had been given during their induction and subsequent training. Staff also told us they were satisfied with the level of support that they were given from the management team. Supervisions, appraisals and unannounced spot check visits were consistently carried out for all staff who supported people.

Staff spoke kindly and respectfully to people and involved them with the care provided. Staff had developed meaningful relationships with people they supported. Staff knew people well and had a caring approach. Staff demonstrated how they would implement the training they received and were provided with additional training when it was identified.

People received personalised care. People's care had been planned and individual care plans were in place.

They provided clear guidance to staff on how to meet people's individual needs. Where risks to people had been identified these were assessed and actions had been agreed to minimise them.

People were involved in determining the care that they received and staff understood how consent should be considered. Staff were vigilant to changes in people's health needs and their support was reviewed when required. If people required input from other healthcare professionals, this was arranged. Staff often supported people with their healthcare appointments.

A range of quality audit processes overseen by the registered manager were in place to measure the overall quality of the service provided. We found the registered was open to feedback and discussions about how the service could be improved.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were not managed safely.

Calls were covered and there was sufficient staff to meet the needs of people.

People and their relatives said they felt safe and comfortable with the staff.

Staff were trained to recognise the signs of potential abuse and knew what action they should take.

Is the service effective?

Good

The service was effective.

People's care needs were managed effectively by a knowledgeable staff team that were able to meet people's individual needs.

Staff received regular supervision and appraisals, attended training and additional training was provided when needed.

People received support with food and drink and made positive comments about staff and the way they met this need.

Staff understood how consent to care should be considered.

The service made contact with health care professionals to support people in maintaining good health.

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and respectful staff.

People were able to express their views and be actively involved in making decisions about their care.

Staff knew the people they supported and had developed meaningful relationships.

People were complimentary about the staff and said that their privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's assessed needs.

Care Plans were personalised and individual to the person being written about.

People knew how and who to complain to if there was a concern about the care they received.

Is the service well-led?

Good

The service was well led.

The service had an open culture that was continuously developing to improve the services for people they supported.

Staff told us that the management were supportive and approachable.

A range of quality audit processes were in place to measure the overall quality of the service provided.

Community links were maintained with external agencies.

Independent Lives (Disability)

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 16 and 18 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection team consisted of two inspectors.

Before the inspection, we examined the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with 11 people who were using the service and five relatives. This included meeting with three people in their own home whilst they were being supported by staff, eight people and five relatives by telephone. We visited the office and met separately with two care staff, one senior support worker, the care quality officer, the deputy care manager and the registered manager. We also liaised with three health care professionals from the local authority to gain their views of the service.

In addition to using general observation we spent time looking at records including care records for seven people. We also read five staff files including training records, medication administration record (MAR) sheets, staff rotas, complaints, accidents and incidents record and other records relating to the

management of the service.

This was the first inspection of Independent Lives (Disability) since a change of legal entity.

Requires Improvement

Is the service safe?

Our findings

Some people received support from staff with their medicines. We observed staff administer medicines to people in their own homes in a personalised and professional manner. People did not express concerns over how staff supported them. We found, however, that-records of medicines administered by staff did not demonstrate that people had received their medicines consistently as prescribed by their GP. Medication Administration Records (MAR) were completed by staff and stored in each person's care file in their home People's MAR were then taken to the office where they were stored and reviewed by the office managers.

People's MARs that we examined contained significant gaps, lacked information on each medicine prescribed and some lacked detail in the times medicines (including creams) were to be administered by staff to people. Where medicines were administered from blister packs the MAR had referenced 'blister pack' as the name of the medicine however did not name the medicine prescribed to be given at a particular time. This meant staff signed the MAR when administering without being able to check that what they had given to the person that visit was correct. In January 2016 one person's MAR had a section named 'blister pack' however had 13 unexplained gaps where staff had not signed. The same record had 14 gaps where staff had not signed for a prescribed cream with no explanation to the reason. Another person's MAR was unclear to what time their medicines should be administered however stated a general 'AM' and 'PM'. The same record did not provide information on the medicines administered and had six gaps where staff had failed to sign and no entries made by staff as to the reason. A third person's MAR also had unexplained gaps next to the 'blister pack' section. In addition one medicine on this record had been crossed out with a comment that read, 'run out'. We established with the registered manager that this medicine was discontinued under the advice from the person's GP however the records remained unclear and inaccurate. The MARs did not provide sufficient information on prescribed medicines and confirmation that people received their medicines as required. Therefore people were at risk of not receiving their medicines safely.

The evidence above showed that the proper and safe management of medicines was not always followed. The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was prompt in taking action in this area. They had already recognised that there was an issue with managing medicines as it had been discussed with staff at a staff meeting in December 2015. The management team had reviewed how staff were supported in this area. By the end of the inspection the registered manager told us they would be introducing a new electronic medicines administration system and reviewing their medicines policy. This meant actions were being taken to reduce the risks to people they supported in relation to their medicines.

People confirmed that they felt safe when staff were in their homes and we observed people looked at ease with the staff who were supporting them. One person told us, "I feel completely confident, I feel safe, no problems at all". Another person described how they felt about the staff and said, "I feel safe with all of them". A third person said, "I feel safe in their hands".

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager and other members of the management team with any concerns. One staff member said they would go to the registered manager if they noticed a change in a person's behaviour and used the example that a person, "Might be very quiet". The care quality officer told us how they saw their role in keeping people safe and said it's about, "Protecting them all day everyday". The care quality officer had management responsibilities which included carrying out spot check visits. The visits included talking to people who used the service and observing staff delivering care. The service had safeguarding adults at risk policy which provided information and guidance on keeping people safe.

Care records found in people's homes and the office contained risk assessments. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risks were managed safely for people and covered areas such as how to support people to move safely, how to support people with the food and fluids they required and how to support a person with catheter care. We found risk assessments were updated and reviewed regularly and captured any changes. For example, one person's physical health had deteriorated in the past six months and had been reflected in their risk assessment, which had last been reviewed in January 2016. Information from risk assessments were transferred into 'task sheets' that provided step by step guidance to staff on how to carry out the necessary support. For example, one person was a wheelchair user and required two staff to support them with some aspects of personal care. The risk assessment and task sheet provided sufficient direction to staff to enable them to carry out their responsibilities safely. Staff told us that they understood the importance of risk assessments. A new staff member told us that if they couldn't find a risk assessment in place they would, "Go to my line manager to make sure it's safe for [named person]".

Accidents and incidents were reported appropriately and documents showed the action that had been taken afterwards by the staff team and the registered manager. This included events that related to the well-being of people. Records showed that the relevant professionals and relatives had been contacted. Actions taken by the office helped to minimise the risk of future incidents or injury.

People told us that there were sufficient numbers of suitable staff to keep people safe and the records we checked reflected this. Records showed that people were provided with two hour time frames when their care would take place throughout the day. For example, one person who had needed one hour of support in the morning was offered between 8am and 10am. The same person told me they were happy with staff coming within that time period however on occasions the evening visit was too early for them. One person said that the service was, "Excellent, no missed calls". Another person spoke very positively about the care they received and explained that the only time staff were late was due to the traffic. A fourth person who received care every day from the service told us, "They always ring if they are running late". A relative told us, "There have been no missed calls and if they over run somewhere else the carers always ring". However one person shared that she found the, "Carers to be excellent" but expressed that they were frustrated when staff that walked to their home were late as they sometimes didn't know the route. Another person described the care as, "Excellent" however expressed frustration when staff were late.

We were able to feedback some of the comments during the inspection to the registered manager. They told us that they had taken action to minimise late calls. They showed us the 'live' online call monitoring system that was introduced in October 2015. The system was connected to all staff's mobile telephones. Staff had to log in when they arrived at the visit and if they failed to do so an alert would be automatically generated three minutes after the agreed visit time. The alerts were picked up by the manager on duty. Out of office

hours alerts were picked up by the on call manager. The registered manager provided a recent example of how the alert received minimised the risk to a person. They shared that the system had improved how they managed staff deployment however were open to further improvements where necessary.

Staff recruitment practices were robust and thorough. Staff were only able to commence employment upon the office receiving two satisfactory references, including checks with previous employers. In addition staff held a current Disclosure and Barring Service (DBS) check. Certificates of qualifications staff had listed on their application forms were held on file, this showed that the authenticity of qualifications had been established. Recruitment checks helped to ensure that suitable staff were supporting people safely within their own homes.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People and relatives told us of the confidence they had in the abilities of staff and they knew how to meet their needs. One person spoke positively to us about the skills of the staff and said that they, "Regularly get updated with all their training". Another person said the staff were, "Very kind and knowledgeable". A third person told us, "They are well trained and I'm very happy". A relative told us, "I can't fault the service one bit".

People received support from staff that had been taken through a thorough induction process and attended training with regular updates. The induction consisted of a combination of up to a week of shadowing more experienced staff, the reading of relevant care records and service policies and procedures. Staff were allowed to have additional shadowing shifts if they were new to working in health and social care. Staff records showed observations were carried out to assess their competency before performing their tasks independently. The care quality officer told us that staff, "Have to have training before they go out in the field or you are putting clients at risk". One person told us the staff were, "Always sent into shadow before they start on their own".

In addition to the service induction the registered manager had introduced the Care Certificate (Skills for Care) for staff to complete. The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. It provides an opportunity for registered managers to provide knowledge and assess the competencies of their staff. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment.

The training schedule covered various topic areas including moving and handling, medicines, dementia and safeguarding. The service used different methods to train their staff including on line training and classroom based. A training officer employed by the provider was supported the staff training programme. In addition, other senior staff were trained to facilitate courses such as first aid, fire safety, moving and handling and food hygiene. The office booked new staff on training accordingly and existing staff on refresher training. Opportunities were provided to staff who required additional skills. For example, some staff supported people with end of life care and the relevant training had been provided to them. One relative told us, "The girls needed some extra training as my husband has a peg feed and this has been sorted out". Staff told us that they felt confident when using moving and handling equipment and we observed staff using their skills to move people safely. This showed that the training they had received was implemented in practice when supporting people in their homes.

Records indicated that nine staff had achieved various levels of Health and Social Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. Staff spoke positively about their induction and training. One staff member had worked for the service for two months and said, "You get a lot of training". They described to us how they enjoyed their job and said, "I feel confident".

Supervisions and appraisals were provided to the staff team and overseen by the registered manager. A system of supervision and appraisal is important in monitoring staff skills and knowledge. A supervision and appraisal plan showed meetings that had taken place. Work related actions were agreed within supervisions and carried over to the next meeting. For example, one record showed where refresher training had been advised and by the next supervision the training had taken place. In addition to formal meetings staff received unannounced spot check visits which took place in people's homes. They included a detailed competency checklist of observations made by the senior staff. One person told us, "They have spot checks done by senior staff to see how [the staff] are doing. I think it keeps them on their toes". The structure of the service divided care staff into five groups led by a senior support worker. The senior support workers were able to support their teams in the community and provided a further link with the office. The care quality officer carried out spot check visits on the senior support workers and told us that they carried out one per month. Staff meetings were also held and where items relevant to their responsibilities and role were discussed. Items included future training plans, information about work telephones and issues pertinent to people they supported. When staff missed a staff meeting a summary of what was discussed was emailed to them.

Additional support for staff was made available in 'Mini-Flash' reports which were sent via email. They contained further guidance in topics such as safeguarding, infection control and other health and social care updates. Staff also received text messages to their work mobile telephones which posed questions to them such as, 'What is the definition of safeguarding?' Staff were expected to respond to the message with their answer. This meant all staff had access to effective support, guidance and training in order to carry out their roles and responsibilities.

People were involved in making decisions which related to their care and treatment. When we visited people's homes we saw people offered choices. Consent to care and treatment was sought in line with legislation and guidance. 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 MCA 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 the least restrictive as possible. Best interest decisions made on behalf of people who lacked capacity were made by various health and social care professionals, the registered manager and team and the relevant family members. Staff received training on the topic and understood how consent should be considered.

Care records showed how consent had been captured. For example one person had signed a consent document for their medicine to be administered to them by staff. The registered manager demonstrated they understood current legislation regarding the MCA and explained that they were able to assess a person's capacity at the initial assessment stage and this was reflected in the care records. Other members of the management team we spoke with showed confidence on the subject of MCA and were also involved in assessing the capacity of people. The registered manager told us they would refer to the relevant social care professionals if changes in a person's capacity were identified for advice and further guidance.

Some people's needs had been assessed with regards to what support they required with food and drink. Others were able to support themselves or received support from family members. People spoke positively about the support they received with their diets. We observed staff talking to people about their breakfast. One person required support to make various drinks that would last between care visits to encourage them to stay hydrated when staff were not there. We observed the drinks that were made and this was reflected in the guidance in their care record. Another care record provided details of a person's preference of porridge for breakfast and how it should be made, yet also stipulated other options should be offered. We heard staff

ask the person if they would like porridge or an alternative. Staff communicated to others what people had eaten and drank in daily records. This meant information relevant to a person's diet was handed over to the next member of staff attending a visit to monitor any changes.

People felt confident that staff could manage their healthcare needs. The support provided would vary depending on a person's needs. Where healthcare professionals were involved in people's lives, this care was documented in the care plan. For example, we noted that GP's and district nurses were involved with some people's care. One person told us, "When I fell ill I wasn't in a position to contact anybody, staff contacted the hospital and the district nurses". The same person told us they had numerous hospital appointments due to their condition and said, "The office staff have managed to accommodate it". The person told us that the office adjusted the times when staff visited. When we asked for the views of a mental health nurse they told us, "I have regular contact with [the service] by email or telephone weekly and all my clients are reviewed on a monthly basis". Staff told us they would report to the senior and the office if they had any concerns about a person's health. Staff were able to contact health professionals directly if there was a need. However new staff told us they were more comfortable going to the registered manager and the office first to gain advice and guidance.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Staff had a caring approach and were patient and kind. Staff smiled with people and looked approachable; their interactions were warm and personal. One person told us, "The staff are exceptionally professional, caring and thoughtful and look after me exceptionally well". When asked for why they felt this way they replied, "They ask me how I am in the morning". Another person said they were happy with their care and told us, "They are very good". A third person shared, "The carers are excellent, absolutely fantastic".

We observed three people supported by staff in their own homes. One person required two staff members to attend each visit for support with moving and handling and some personal care. Staff were polite and relaxed in their approach and were heard talking about topics of interest to the person they were supporting. One staff member was heard asking the question, "Did you play the piano then?" The person seemed to enjoy the level of conversation and fully participated. Another staff member was observed talking to one person about the football results. One staff member asked us to wait outside a person's home whilst they checked whether they were still happy talk to us. This showed that staff considered the person's wishes when supporting them and used a personalised approach. Most people told us that they received care from the same staff consistently and this was reflected in the care records. One relative told us, "We have the same carers which is great for [named person] as it gives continuity." However one relative did say, "The carers do change an awful lot…but the ones that do come are brilliant. They do a very good job of looking after my [named person] beautifully".

People were encouraged to be involved with the care and support they received. People and relatives told us that they felt included in decisions about their care. We observed staff involve people in their day to day decisions surrounding their personal care and meal preparation needs. One person who told us, "They ask me what clothes I would like to wear". People were aware of the contents of the daily files that were kept in their homes. They included contact information, their care plan and other daily monitoring forms pertinent to the individual. People with capacity were encouraged to sign documents within their files which showed they were involved with the care they received. One person told us that they knew about the file and its contents and said, "It's pinned up in the kitchen and new staff always refer to that before they start".

People were given opportunities to make comments to the service and review their care. Staff told us they included people with their support by, "Asking them if they were comfortable and happy with the support". One staff member described how people had been supported to be as independent as possible and said, "Yes, people are involved…we do it together". People were asked questions by the management team during spot check visits of how they found the care they received. The information was then reviewed by the office to enhance the quality of the care provided to people. This meant that people were provided with regular opportunities to express their views and be involved with their care.

People were supported by staff who promoted and respected privacy and dignity. We observed staff members were sensitive when supporting people. Staff used the appropriate tone and pitch of voice when supporting people with personal care. Staff were seen knocking on people's doors before entering and

explained what they were going to do during the visit. One relative said, "The carers are very understanding and look after [the named person's] pride". When we asked staff how they promoted privacy and dignity when supporting people they were able to provide examples. One staff said, "If they are on the telephone we walk out the room". They also shared they would close doors when supporting people with personal care. Another staff member told us, "I cover up people when providing personal care".

The service supported one person with end of life care at the time of our visit. The staff member engaged and communicated sensitively with the person. They worked in accordance with the care plan in their home. They checked with the person that they were happy with the care provided and were led by the person's responses.

Senior staff and managers carried out spot check visits which were a practical assessment of staff and their care practice. The form used to document the spot check included, 'Demonstrate respect for the client's privacy and dignity at all times'. The information received was reviewed by the office and overseen by the registered manager. Audits of the comments made by people were addressed and actioned. This showed how the service encouraged the staff to respect people they supported and encouraged a caring approach.

Good

Is the service responsive?

Our findings

Staff knew people well and responded to people's needs in an individualised and personalised way. One person told us the service, "Always tries to support me". Another person said, "I feel in control of my care and how it is given".

People and relatives told us they were involved and aware of the care records in place. Care records included a care plan, risk assessments and other information relevant to the person they had been written about. Care plans were reviewed regularly and included information provided at the point of assessment to present day needs. Each person had a care plan within their home and a copy was also kept at the office. The care plans provided staff with detailed guidance on how to manage people's physical and/or emotional needs. This included guidance on areas such as skin integrity, mobility and continence care. People's preferences and consent to their care was captured. Care plans showed how people were involved in all aspects of their care and where that was not possible the involvement of family members was used. One person told us, "I'm always involved with the care plan, the seniors sit down with me and look at things that are working and the things that need to change". A relative said, "They always let me know if they make changes to [named person] care plan". Another relative shared that their family member was involved in the [named persons] care plan and said, "He talks through any changes with the girls".

Staff knew how important the care plans were and told us how and where they would find certain information to enable them to carry out their roles and responsibilities. A senior support worker who was involved in writing care plans told us they were. "Always assessing people's needs". Another staff member told us, "You can read the background on a person in their care plan", and also said, "They get reviewed by seniors once a month". One staff member told us that they were always checking the care plan to see if anything had changed for the person they were supporting.

Daily records were completed about people by staff at the end of their visit. They included information on how a person presented during the visit, what kind of mood they were in and any other health monitoring information. Changes to people's needs were highlighted through various methods including reviews, spot check visits and speaking to people and families direct. In addition to traditional methods, staff received updated information on a person's needs via a secure email prior to the visit. Information was sent to staff routinely as part of their rota before the support was provided. Therefore staff were prepared and able to respond to people's current needs and amend their practice accordingly.

People told us that if they had any concerns they knew who they would go to and were able to name seniors and managers in the organisation. A complaints policy was in place and was reviewed in January 2016. Our observations indicated that complaints and queries were responded to in good time by the service. This was reflected in the complaints audit kept at the office. One person, who spoke positively about the service, told us, "Occasionally they might have problems but they are overcome". Another person commented that they would go to the senior in the first instance. However if they were not working told us, "I contact the office they are very good". A relative told us of an issue they had in the past and commented, "We had a bit of a hiccup early on…but the office sorted it out". Another relative said, "There was an issue about my

morning call but it was eventually sorted out". Another person said "I have no complaints". An entry in the complaints log in August 2015 showed how such a complaint was managed. The complaint was about a 'lack of rota information' and detailed how the service had changed its practice from emailing rotas to posting them.
However some people shared frustrations with a lack of communication from the office regarding staff arrangements. Comments included rotas not being provided long enough in advance, changes to the staff who attended the visits and on occasions when staff were running late. One person told us, "Better communication from the office would help things". Another person said that their only criticism would be, "The office rotas not out on time, and doesn't always correlate with the rotas that the carers have".

During the inspection we were able to feedback to the registered manager that some people were not happy with the communication from the office. They were keen to show us how they used all feedback from people to improve their service. We were told that all rotas were now sent to people to arrive the weekend before the start of the week. Other complaints recorded showed how the service had amended its practice as a result. The registered manager was open to driving improvements to ensure people they supported were listened to and their concerns responded to.

Good

Is the service well-led?

Our findings

The majority of people and relatives shared positive experiences about the service and the care they had received. One person told us, "Best form of community care, I can't praise them enough". Another person said they were, "Very happy" and had recommended them to others. A third person spoke affectionately about the staff and the management team and said, "They are a very good organisation". We asked for the views of a representative of the West Sussex commissioning team and they said, "I found them to be professional and appropriate", when referring to their experiences of the service.

The structure of the service ensured that people and staff were offered various levels of management support. This meant people were provided with opportunities to discuss the care they received regularly. Care staff described the service as having an open culture and were able to share the visions and values of the service and used phrases such as, "Continue to provide a high level of care" and "Treating every person as an individual". Staff found the registered manager to be approachable and told us, "Issues get acted on…we get listened to". Staff meeting records reflected staff involvement in the care that was delivered by the service. Another staff member described the management and leadership as, "Fantastic". When asked why they replied, "I feel respected". When staff experienced personal issues that impacted on their well-being advice and support had been provided. Staff records demonstrated that staff were encouraged to develop professionally. The registered manager told us that she promoted an open door policy and said, "If you have got a problem come in and talk to me".

The registered manager told us how people and relatives helped develop the service they delivered. For example, relatives had been involved with interviewing new staff. The registered manager told us that a future aim was to include people who use the service to assist in interviewing new staff. She said, "Customers to be involved in the future", when referring to recruitment.

A range of robust audit processes were in place to measure the quality of the care delivered. Audits had been completed in areas such as care plans, supervisions and complaints. People, relatives and staff were encouraged to share their views within a 'quality questionnaire' on the service as part of the audit process and this was reflected in records held at the office. Audit logs were overseen by the registered manager, were easily accessible and carried out every six months. We examined audit records from January and February 2016 however reviews dated back to 2014. Care review's were held with people that use the service once or twice per year. Review audits included various issues, the subsequent action taken and ranged from minor issues to more serious care related themes. One entry read, 'They do not want [named person] carer anymore', there was a note of the action that they no longer worked for the service. Another entry stated a person had been, 'Nursed in bed, moving and handling issues' and the action taken by the care quality officer was 'occupational health referral been made, awaiting for a sling to arrive'. The registered manager attended a monthly quality monitoring meeting with her line manager where audit reports were produced and discussed.

The registered manager worked alongside the local social services teams to assist in meeting the needs of the people the service supported. She had recently taken part in a project that focused on safeguarding

policy and procedures and training in line with the Care Act 2014. This meant they were able to share current legislation and knowledge with the staff team and other management colleagues.

Independent Lives (Disability) care service is part of a much wider organisation which provides various support to people living with disabilities. This included advocacy support and financial support to people with disabilities and other complex needs. The registered manager worked alongside the other project managers and accessed their support on behalf of people when a need was highlighted.

Shortfalls had been identified during the inspection and shared with the registered manager for her to review. However she presented as open and passionate about providing good care and was quick to take action. We asked what was her biggest achievement in managing the service. She chose to share an example of a person that, despite difficulties, the service had managed to continue to support for a number of years. The deputy service manager shared how proud they were about what they had achieved so far and said, "We treat them as individuals", when referring to people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed properly or safely. Regulation 12 (2) (g)