East Living Limited

East Living - Domiciliary Care Service

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17, 18, 19 and 21 October 2016 and was announced. The provider was given 48 hours' notice as they provide a domiciliary care service and we needed to be sure staff would be available to speak with us. The service was last inspected in January 2014 when it was compliant with the outcomes inspected.

East Living Domiciliary Care Service provides care to people in their own homes. This takes the form of supported living schemes for adults with learning disabilities and extra-care and sheltered housing schemes for older adults. At the time of the inspection 77 people were receiving personal care.

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.

The service had robust measures in place to ensure that people were protected from avoidable harm and abuse. Staff were knowledgeable about safeguarding adults from harm and were familiar with the provider's policy on safeguarding. Records showed that concerns about abuse were escalated appropriately. People told us they felt safe.

The quality of measures in place to reduce and mitigate risks faced by people receiving a service varied across the schemes. Some schemes followed best practice, particularly regarding risks associated with behaviour which challenges services. However, in other schemes risks had been identified but the measures in place to mitigate them had not been captured. We have made a recommendation about risk assessments.

People were supported to take their medicines by staff. In most cases medicines were managed in a safe way, with detailed plans in place to inform staff about how to support people to take their medicines and regular audits to ensure the service was managing medicines safely. However, practice was inconsistent across the services and audits and plans were not always in place. We have made a recommendation about medicines management.

Staff were recruited in a safe way which ensured they were suitable to work in a care setting. New staff received a comprehensive induction including a period of shadowing more experienced colleagues. Staff spoke highly of the training opportunities and support available to them. This included access to specialist external training.

Care files contained records showing that people had consented to their care. Where people lacked capacity to consent to their care best interests processes were recorded. Where people had legally appointed decision makers records were less clear and it was not always possible to tell who had the legal right to

consent to aspects of care and treatment. We have made a recommendation regarding records of legally appointed decision makers.

Care files contained details of people's health needs and how they liked to be supported to have their health needs met. Where appropriate people had health action plans and health passports in place to facilitate communication with health professionals. Health information was recorded in different places in people's files and it was not always easy to locate the most up to date information or records of health appointments. We have made a recommendation about recording health information.

People told us they thought staff cared about them. Staff told us they had time to develop caring relationships with people they supported. Care plans were highly personalised and contained details of people's choices, preferences, cultural and religious needs. Plans contained details of people's dietary preferences and where it was within the remit of the service there were details of how to support people with activities of their choices. The level of detail regarding support to meet people's personal care preferences varied across the services and care plan documentation was not used consistently across the services. We have made a recommendation about care plan documentation.

The provider had developed a dignity charter with involvement of people who received services. Each service had a dignity champion within the staff team and staff and residents meetings showed the dignity charter had been discussed. The provider had completed themed supervisions with staff and a dignity survey with people who received a service. Dignity in care was embedded in care plans viewed.

The provider had a robust complaints policy and records showed that people who complained were satisfied with how their complaints were resolved. Records showed that complaints made at services were not always escalated to the central complaints process. The provider was aware of this and was taking action to address this.

The provider conducted various initiatives to ensure the mission and values of the organisation were embedded across the service. This included the use of a 'theme of the month' which included events for people who used services, training and workshops for both staff and people, themed supervisions and resource packs. The provider had staff recognition awards for staff who demonstrated the values of the organisation in their work. Staff told us they felt part of the provider organisation and supported in their roles.

The registered manager and scheme managers completed regular quality assurance audits of the schemes and these led to reports to the board of the provider to ensure high level oversight of the services. Records showed the audit process had led to improvements in services that had been performing poorly. However, the audits had not addressed the inconsistencies in risk assessments, medicines management and care planning identified on inspection. We have made a recommendation about using quality assurance to achieve consistency across different services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The quality and detail provided in risk assessments varied and was not always sufficient to mitigate risks faced by people receiving a service.

Medicines were not always managed in a safe way.

People told us they felt safe.

Staff were knowledgeable about abuse and knew how to safeguard people from avoidable harm.

Staff were recruited in a safe way.

Is the service effective?

Good

The service was effective.

Staff received sufficient training to develop the knowledge and skills required to perform their roles. Staff were able to access highly specialist external training through a funding application scheme.

Consent to care, and best interests decisions where people lacked capacity were clearly recorded. It was not always clearly recorded where people had legally appointed decision makers.

People had detailed health related care plans and were supported to have their health care needs met. Information regarding support to meet people's health needs was not always easy for staff to find.

Care plans contained details about people's dietary preferences. People were supported to eat and drink enough and to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People told us they thought staff cared about them and supported them well.

The provider had involved people in the development of a dignity charter which had been embedded throughout the services.

People were involved in making decision about their care. Their religious and cultural preferences were included in their support plans.

Is the service responsive?

Good

The service was responsive.

People were involved in activities of their choice across the schemes.

People were involved in writing their care plans. Although some care plans lacked sufficient detail, most were highly personalised and kept up to date.

The provider had a robust complaints policy. Records showed complaints were resolved in line with the policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The audits in place had not identified the inconsistencies between the services.

The provider had a clear mission and values which were embedded across the services.

The provider had management systems in place to ensure there was oversight and quality assurance mechanisms in place.

The provider had systems in place to ensure that staff and people who received a service were involved in developing the direction of the organisation.

East Living - Domiciliary Care Service

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 user the Care Act 2014.

The inspection took place on 17, 18, 19 and 21 October 2016 and was announced. The provider was given 48 hours' notice because the location provides personal care to people in their own homes and we needed to be sure that someone would be available to talk to us.

The inspection was completed by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who received personal care in their own home.

Before the inspection feedback was requested from local authority and clinical commissioning group commissioning teams, and the local Healthwatch. We reviewed the information we already held about the service, including statutory notifications.

Before the inspection people who used the services, relatives, community professionals and staff were sent questionnaires to provide feedback on the service. This information was reviewed. 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.

During the inspection we spoke with 13 people who used the service and one relative. We spoke with 13 members of staff including the nominated individual, the registered manager, a locality manager, a scheme manager, a deputy scheme manager, a team leader, the recruitment manager, the training and development manager, and five support workers. We reviewed nine people's care files including care plans,

risk assessments, medicines information and records of care delivered. We reviewed nine staff files including recruitment records, training information and supervision records. We also looked at various meeting minutes, audits, action plans and documents relevant to the management of the service. We visited the head office of the provider, one supported living scheme and two extra-care sheltered schemes.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe receiving a service. One person said, "I feel very safe, it's all good, I feel at home here." Another person said, "It's safe here, they [staff] are friendly and there if I need help." Staff were knowledgeable about the different types of abuse the people they supported might be vulnerable to and were confident in their role in protecting people from harm. One member of staff told us, "I would write it [the allegation of abuse] and escalate it straight away for investigation. Abuse is very serious."

Records showed that staff completed both online and face to face training in safeguarding adults. In addition, the provider held a safeguarding theme of the month where updated policies were shared with staff and staff received specific safeguarding supervisions and team meetings. Records showed that in some of the services this had included people who lived in the schemes having themed meetings around abuse and how the provider would support them with this. Records showed that when there had been concerns about abuse these had been appropriately recorded and escalated to the appropriate safeguarding teams with measures in place that ensured that people were not exposed to further risks of harm. This meant the service ensured people were protected from avoidable harm and abuse.

People gave us mixed feedback regarding the staffing levels at the services and this reflected the variety in the services provided. One person said, "I think there is plenty of staff." Another person said, "They are mostly on time and regular." However, other people commented their experience of staffing levels was affected by the use of agency staff. One person said, "It's [staffing levels] a bit hit and miss. There are too many agency staff and the timings are not the best." Despite this, people were consistent in their feedback that they did not feel rushed by staff when they did attend and their care visits were an appropriate length. One person said, "I never feel rushed." The registered manager told us they were aware the permanent staffing levels at one of the schemes had been low and had resulted in high use of agency staff. The provider had implemented a recruitment strategy and had made offers of employment to new staff. These staff were completing their induction periods during the inspection and records showed use of agency staff had reduced significantly in the two months before inspection. Records showed that the services used a combination of permanent and sessional workers with agency cover where required to ensure that staffing levels were maintained at a safe level.

The provider had a central recruitment team who managed the recruitment process for new staff. Scheme managers submitted requests for recruitment to the team who then managed the process centrally. Following an initial application form submission candidates were invited to interview. Records showed the interview process was values based and completed by at least two managers who scored candidates based on their answers. The provider had introduced literacy and numeracy assessments to ensure that staff had the skills required to perform their roles. The provider was in the process of introducing further assessment of candidates to ensure they had the attitudes and behaviours the provider wanted to see in staff. Following a successful interview the provider used an external company to collect references and check employment history details provided. The service ensured that staff had completed an up to date criminal records check to ensure they were suitable to work in a care setting. The provider had a robust process in place to risk assess where potential staff had criminal records on their disclosure. The provider completed checks to

ensure staff had the right to work in the UK including checks of applicants' identity. This meant the service had ensured they had recruited suitable staff.

People living in schemes had a range of risk assessments to inform staff about the risks people faced and how to mitigate against them. The quality of risk assessments varied across the schemes. At some of the schemes risk assessments were highly detailed and personalised including clear records that people had been involved in developing measures to protect them from harm. In the learning disability supported living services people had comprehensive positive behaviour support plans in place in line with best practice for supporting people who present with behaviour which can challenge services. The level of detail provided to staff on how to support people to manage risks was high. For example, there were clear instructions on how many times to answer the same question and a script for how to respond if that person's behaviour started to escalate. This service had a range of individual risk assessments to address risks including those relating to behaviour, health issues, personal care, cooking, accessing the community, mobility and managing finances.

However, at one of the older adults extra care sheltered schemes risk assessments were not consistently in place or detailed. For example, one person had been identified as being at risk of developing pressure wounds but there was no risk assessment in place to inform staff of how to manage this risk. The deputy manager explained the measures that were in place, including the use of pressure relieving equipment, but these had not been captured in a written risk assessment and were not available to new staff joining the service. The service took immediate action to update this person's risk assessments. Another person was identified as having epilepsy. There was no risk assessment regarding seizures in this person's file. This meant staff did not have information available to them on how to mitigate the risks associated with seizures. A third person was identified as being at risk when mobilising. However, the instructions for staff were not detailed enough to provide them with the information required to complete tasks safely. Their plan stated "[Person] requires support to sit up in bed and to stand from a sitting position whist she sits on her bed." At another service, one person was identified as being at risk of depression. Their risk assessment stated the control measure was "[Person] has learned to cope." This was not a sufficient measure to mitigate the risk that this person suffered a recurrence of depression

We recommend the service seeks and follows best practice guidance about sharing risk assessment and risk mitigation strategies across the services.

People told us they were supported by staff to take their medicines. One person said, "They [staff] give me my tablets every morning and special drinks twice a day. They check if I am running short and replenish them." Records showed staff were trained in how to administer medicines in a safe way both through in-house training from the provider and external training provided by the pharmacist the provider had a contract with. The safety of the management of medicines varied across the schemes. In two of the schemes visited people had detailed medicines care plans which contained details of the medicines they had been prescribed, their purpose and how to support the person to take them safely. These included clear guidelines for staff to follow regarding medicines that were prescribed on an 'as needed' basis. Records in these schemes showed that people had been supported to take their medicines as prescribed. Records also showed staff completed regular audits of medicines stocks to ensure that people had the right amount of medicines available to them.

However, in one of the extra care sheltered housing schemes people did not have medicines care plans in place and there was no information available to staff regarding what medicines people were taking, why they were taking them or how they wished to be supported to take them. Staff relied on the information provided on the printed medicines administration records supplied by the pharmacist. These were reviewed

and showed that medicines that had been discontinued were still listed. There was no record to show that this medicine was no longer required. This meant staff did not have up to date or accurate information on what medicines to administer.

Although most people living in this scheme received their medicines in monitored dosage systems, some people did not and their medicines were supplied in standard packaging. The medicines records in use had a section where staff should record the amount of medicines received and maintain a running total of medicines available. However, these had not been completed. This meant the service could not ensure they had the correct amount of medicines in stock. Despite monthly management audits of medicines being completed at the scheme this issue had not been identified or acted upon. The provider submitted detailed medicines plans after the inspection which included the details of what medicines people were taking, any risks associated with these including guidance for staff on symptoms that would require escalation of concerns and details on how to support people to take their medicines.

We recommend the service seeks and follows best practice guidance about the management of medicines.

Good

Is the service effective?

Our findings

Staff told us they received the training they needed to perform their roles. One member of staff said, "I'm happy with the training I've had. We're given opportunities to update and can book ourselves on training we are interested in." Another member of staff said, "They [provider] are top on their training." Records showed that training opportunities were cascaded to staff by email who could then book themselves onto required training courses. Managers were sent regular reports regarding training levels of their staff so they could prompt staff to book themselves onto training courses that were due.

Records showed staff completed a range of training courses appropriate for their roles including, support planning, lone working and personal safety, infection control, food hygiene, behaviours that challenge, moving and assisting, nutrition, dementia, communicating with people with complex needs, equality and diversity, learning disabilities, person centred planning, risk assessment, record keeping, and training on specific health conditions that people they supported lived with. New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. Records showed that team meetings and group supervisions were used to reinforce key messages from training courses and that competency assessments were completed by managers within schemes to ensure that staff had retained the knowledge acquired on the training course.

The provider had a system where staff could apply for funding for specialist external training. A manager had utilised this scheme in order to complete a master's degree in positive behaviour support through a leading organisation in the field. Records showed the knowledge and skills acquired through this course were being applied on a daily basis in the service. Records showed team meetings had been used to share knowledge across the staff team. This meant people were receiving consistent support from staff who had developed a thorough understanding of the approaches behind the support plans in place. The provider had also facilitated other managers to complete qualifications in person centred planning practice and dementia care. This included train the trainer aspects so these staff were able to cascade the knowledge they acquired throughout the organisation.

When new staff joined the service, or moved to a new scheme within the service, they completed a comprehensive induction programme which included a week of shadowing more experienced staff. Staff told us they felt they had time to get to know the people they were supporting during this time. Staff told us they received regular supervision from their line managers. Records showed that supervision was used to discuss issues relating to the people being supported, to provide the opportunity for reflection on any incidents or issues that staff had found challenging, as well as monitoring of key performance indicators including support planning, complaints and training. This meant the service ensured that staff had the knowledge and skills to carry out their roles and responsibilities.

People's care plans contained details of their support needs in relation to eating and drinking. Where people were identified as being at risk of choking there were records of the involvement of appropriate health professionals with clear guidance in place for staff on how to support people to eat and drink safely. Records

showed that people were supported to plan their meals, complete shopping and cook their meals where this was part of their agreed support plan. At one of the extra-care sheltered schemes one hot meal a day was included as part of the support package. Mealtime observations showed that people were offered choices of hot meals from a varied menu. Records showed the catering team met with people living in the service to receive feedback regarding menu options. Where people did not like the options available observations showed they were offered an alternative that was freshly prepared for them.

Care files contained details of people's health conditions and the support they required to maintain their health. Where appropriate people had health action plans in place with details of relevant health professionals' involvement and up to date health advice. These contained details of regular appointments that people attended and how to support them to engage with health professionals. People also had hospital passports containing key information that health professionals needed to know when providing emergency care to people.

In some care files health information was located in various different places within the files. For example, rather than having health information in the section titled 'physical health' it was located in the risk assessments section. One person's safety care plan contained details of their health conditions including diabetes, dementia and physical disabilities. However, their health related plans only referred to their physiotherapy exercises. Although it was possible to find all the information relating to their health within the file, the fact that it was not located in the section titled health meant there was a risk that health information may be missed by staff. In another of the services, records of health appointments or advice from health professionals had been recorded in a number of different places. Although records showed health advice had been followed, it was not clear how this had been communicated to staff and this meant there was a risk that not all health information would be shared appropriately.

We recommend the service seeks and follows best practice guidance on clearly recording health related support needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Care files contained various consent forms which people had signed to indicate their consent to care. For example, people consented to the overall package of care, for staff to hold keys to their homes, for medicines administration and for support to manage their finances. In the learning disability services and one of the older adults sheltered housing schemes there were clear records of best interests decision making where people had been assessed as lacking capacity to make a specific decision. Records included the efforts that the service had gone to enable the person to understand and make the decision for themselves.

Records regarding where people had legally appointed decision makers were inconsistent in one of the extra care sheltered services. People can be appointed to be decision maker regarding two types of decision, welfare and finances. Records showed that where people were appointed to make decisions regarding finances they were also consenting on welfare decisions. In other files it was not clear whether the person had capacity to consent to their care or not. For example, two people had signed consent forms in

their files, but other parts of their plans referred to their relatives having a power of attorney. Only one of these people had a record of the power of attorney documents which showed this related only to financial decisions. In all these cases record showed that the service had involved people and their relatives in making decisions about their care and treatment.

We recommend the service seeks and follows best practice guidance around consent and legally appointed decision makers.

Good

Is the service caring?

Our findings

People told us they thought staff were kind and caring. One person said, "I have very good carers." Another person said, "They like you and talk nicely. They give me confidence." A third person told us, "I was falling to pieces and they are great company for me." Further comments included, "They are wonderful, they never let me down." And, "They are very caring and very good." The only criticisms of staff attitude related to the use of agency staff whose attitude was contrasted with that of the permanent staff. For example, one person said, "Agency staff can be less caring, they are more matter of fact."

Staff told us they had time to get to know the people they supported when they joined the service. One member of staff said, "I had a week shadowing to help get to know people before supporting them on my own." Care plans showed staff collected and used information from people and their relatives about people's interests and lives before they lived in the services. The service incorporated information regarding people's religious and cultural preferences and significant relationships into care plan documentation. Staff demonstrated they understood the impact people's pasts and preferences had on how they wished to receive support. One member of staff said, "Everyone has their own way that they want you to support them. We have to give people options."

People's religious beliefs and the support they wished to receive to maintain their faith was clearly recorded in their care plans. Where people wished to be supported to attend religious services this was facilitated. In addition, representatives of faith groups visited the services where this was requested by people living in the schemes.

The provider had involved people who received a service in the development of a dignity charter. This was launched across the organisation in February 2015 with a "Dignity Month" when the organisation encouraged staff to sign up to the dignity challenge established by the Department of Health and Social Care Institute for Excellence. This involved a series of events and workshops for both staff and people receiving a service. Records showed the dignity challenge and charter were discussed at staff and residents meetings and each service had a dedicated dignity champion among the staff team. The provider had completed a dignity survey and audit to evaluate if people felt they were treated with dignity by their staff. The survey showed people felt they were treated with dignity and respect by their staff.

Staff were knowledgeable about how to protect and promote people's dignity during care. Staff told us they ensured people's privacy by keeping doors closed and ensuring they were not interrupted. Staff demonstrated sensitivity to the intimacy of personal care. One member of staff said, "[Person] is very self-conscious about being naked in front of us. We are working with them and their family to find ways of supporting them." This was embedded in care files, where instructions for staff included details of how people liked to be greeted. One file stated, "I don't mind if you use my doorbell but sometimes it can startle me. I like to be greeted with a smile. Please ask me how my night was."

Records showed that the schemes held meetings for people and their relatives to obtain feedback and to include people in making decisions about the service. Feedback regarding how useful these meetings were

varied by service. One of the schemes had recently changed management and people and relatives from this scheme did not feel that meetings led to changes in how care was delivered. Records showed the new management team in place was taking steps to ensure they were able to show people and relatives that they were responding to their feedback.

Good

Is the service responsive?

Our findings

Care files contained details of people's preferences for activities and the service's role in supporting people to participate in activities both in the services and in the wider community. One person told us about the different activities the service supported them to be involved in including swimming, going to the gym and going on holidays. The sheltered housing schemes had developed links with a dementia day service who visited the schemes on a weekly basis to facilitate activities. Staff also provided a range of in house activities including reminiscence groups, bingo and music groups. Records showed that bigger events such as barbeques and parties were also completed at the schemes. At one of the schemes staff and relatives raised that it was challenging for staff to facilitate activities on a regular basis due to lack of dedicated time to plan and facilitate activities. This meant that some relatives felt their expectations about the level of activities provision had not been met.

The provider ran a range of activities and schemes for people who lived in all their services, both those included in the provision of personal care and other housing schemes. These had included annual arts competitions as well as performance competitions. The provider had run a talent show and was currently seeking interest and competitors for a dance competition. As part of the disability awareness month people had been invited to participate in sports events in the run up to the launch of the Paralympics in Rio 2016.

The provider had a central complaints process for formal complaints. The provider had launched a renewed complaints policy which focussed on resolution of complaints through open communication with complainants. Records showed complaints logged through this process had been thoroughly investigated and resolved to the complainant's satisfaction. The central team audited complaints on a regular basis and produced a report on themes and lessons learnt that was presented to the board of the provider. These audits had identified that communication issues were the main theme of complaints made through the central process. Records showed that three complaints regarding the service had been made through the central process.

Record showed complaints made locally at the schemes had not always been escalated to the central process. For example, one of the schemes had records of five complaints, only one of which was also recorded in the central system. Relatives of people living in this scheme told us they did not think that their complaints had been appropriately responded to. The management of this scheme had recently changed and the new manager was aware of these issues and had started a programme of engagement with relatives to address historic complaints.

Records showed that each of the schemes held regular meetings for people who received a service. These were used to discuss activities, feedback about staff and the service. They were also used to provide information regarding the themes of the month. Records showed people were advised of training opportunities for people who received a service that the provider offered. These included being involved in recruiting staff, computer skills and abuse awareness.

Each care file viewed contained a detailed one page summary of key information required as a starting point

to get to people and their care needs. These contained details of people's likes, dislikes, personalities and key information staff needed to know. They were consistently completed to a high standard across the schemes and provided a solid introduction to people. For example, one profile stated, "I love to get up early and go to bed late. I do not like to sleep." Details included how to support this person's sensory needs. Another plan explained that while the person was a football fan, they had felt obliged to change their team loyalties for a relative.

The provider's assessment and referral process ensured that key information regarding people's needs and preferences including equalities information relating to protected characteristics under the Equalities Act 2010. People's preferences regarding the gender of staff providing person care was clearly recorded. Records showed the provider worked with people, their relatives and relevant professionals to ensure that the care plan in place was suitable to meet people's needs. Records showed that people's care plans were reviewed at least annually and were updated more frequently if there had been changes in people's needs. Staff were confident in how to escalate concerns that people's needs had changed. One member of staff said, "If someone's needs changed I would report it for re-assessment. I'm the type of person who would push and push." People told us they were confident the service would amend their support if needed. One person said, "[If support needed to change] you would talk to them, they are very good. " Another person said, "There have been a couple of changes, it hasn't been a problem."

People told us they had been involved in writing their care plans. One person said, "I have read it [my care plan] and I was involved when it was written." The provider had recently changed the format of care plans to make them more accessible to people who used the service. Staff told us the new format was more user friendly than the previous one. One member of staff said, "The old format was difficult for staff and for people. They [provider] listened and changed the format so it's easier to do."

Care files at two of the schemes visited contained a very high level of detail about how to provide support to people in a way that met people's needs and preferences. For example, staff were provided with step by step instructions on how to support people from greeting them through waking up, all stages of personal care including the location of equipment and preferences for toiletries and water temperature. Where people preferred to perform care tasks in a specific order this was clearly recorded as were the details of which aspects of the tasks people could complete without staff support. These documents also included instructions for staff on where to offer people choices and how to present choices so that people could engage with them. For example, one person was to be offered a choice of three clothing options all of which would be suitable for the weather conditions. Staff were advised to lay out the outfits for the person to choose from after they had completed their care.

In the third scheme visited although the level of detail about people's preferences and personalities was of a similarly high standard, the instructions for staff regarding how to support people with their care were not detailed. Care plans stated that staff should, "Assist me with all aspects of my personal care." This person was unable to use speech to communicate and this was not sufficient information to ensure that staff completed this person's personal care in a way that met their preferences. Another person's plan stated, "Assist personal care / toilet / get dressed." This is not enough information for staff to know how to provide this assistance. This meant the quality of care plans was not consistent across the different schemes the service provided.

The new format contained two documents, a support plan and a service delivery plan. In some of the schemes these documents were identical. In other schemes the support plan was used for more general information about the areas the person needed support with and the service delivery plan was used to record the detail of personal care tasks to be completed. This meant that it was not always clear where to

look for the most pertinent information required to provide support to people. Staff told us that although care plans contained good information about people and helped them build relationships with people, it could be challenging to read all the information required to provide good support. One member of staff said, "The information is there, but it's not always easy to find." Another staff member said, "New staff don't really have time to go through all the care files, it can be a bit much at first." The format of the documentation meant there was a risk that staff would miss key information as it was not easy to find.

We recommend the service seeks and follows best practice guidance about achieving consistency in care plan documentation.

Requires Improvement

Is the service well-led?

Our findings

The provider conducted a number of initiatives to embed the values of the organisation across the staff team. These included themed supervisions, training events and workshops that were cascaded through team meetings as well as email bulletins. The provider also operated staff recognition awards where staff were nominated to receive a small financial bonus and featured in the provider's newsletter if they had worked in a way that demonstrated the values of the organisations. Copies of the provider's values and corporate commitments to dignity and care were on display throughout the schemes. The provider had a number of mechanisms for staff and people who received services to be involved in developing the strategy of the organisation and ways for staff to communicate directly with senior managers of the organisation. These included direct email access to senior managers, drop in sessions for staff as well as all senior managers within the organisation committing to a "Back to the Floor" day where they spent a day in one of the services. There were steering groups for people who used services which influenced the strategy and development of the organisation. There were systems in place, with cash rewards, for staff to contribute to the strategic direction of the organisation.

The registered manager told us that the organisation had worked to ensure that the services provided felt linked and part of the wider provider organisation. Feedback from staff was that progress had been made in this area. A member of staff said, "Lately we feel more part of [provider]." Another member of staff said, "In recent years it feels more connected. We go to head office more now and feel welcome there." The provider had recently achieved gold status in a nationally recognised awards scheme for employers. This recognised their staff involvement initiatives.

Records showed that each scheme held regular staff meetings. Records showed that staff received annual appraisals in line with the provider's policy. These were framed around the values and aims of the organisation and included a self-evaluation of how staff had demonstrated the values in their work. In addition, management initiatives including the use of a 'huddle board' to record key information about the scheme including quality assurance measures and key handover information had been implemented in some schemes.

Feedback from people regarding management varied. Some people told us they thought management was effective and easy to contact. One person said, "They [management] are always helpful." Another person said, "They are very approachable and ring me every morning." A third person said, "I have no complaints about any of the office staff. I think management do a good job looking out for us." Other people were not satisfied with the management of the services. One person said, "It's a waste of time going to the office. If I have a problem I get a relative to deal with it as they listen to her." Another person said, "They don't do what I've asked. Management is not available and trying to find someone is difficult." The provider had identified issues with the management of one of the schemes and had put measures in place to address these. At the time of the inspection the new management arrangements had been in place for less than two months and as such the impact of changes had not yet been embedded. Staff told us they were optimistic about the change in management. One staff member said, "It feels better now, you know things [issues with the service] will go to manager's meetings now." Another member of staff said, "Things are changing now. [New

scheme manager] is going a good job."

The provider had a system whereby scheme mangers completed monthly self-audits of their services which were submitted to the registered manager to review. There was also an annual system for managers to peer audit each other's services. These audits considered care plan documentation, risk assessments, medicines, health and safety, the physical environment, observations of care, incidents, accidents and safeguarding, complaints, staffing records, training, activities and activities. These audits generated an action plan in the services. Records showed that where these audits, combined with local authority monitoring visits had identified serious concerns about schemes clear action plans had been put in place. Records showed that these services had improved.

The registered manager collated the information collected from audits and information from these were presented at board level. This meant the provider had senior level oversight of the services. The registered manager was the chair of the local registered manager's network which was used to share good practice and innovations among registered managers locally. The provider had recently re-developed the induction for scheme managers to make it more robust. Scheme managers had regular meetings where good practice and challenges could be shared. The provider had submitted applications for an additional manager to become registered. This was in response to feedback that the role of the registered manager, which included additional oversight of other services on the provider's portfolio, was too large. The registered manager told us they felt supported by the provider. They told us the changes in progress were positive and would support more robust quality assurance processes.

There were inconsistencies between the schemes identified during the inspection. These related to the management of risk, detail of support plans and management of complaints. This meant the audits had not been effective at ensuring a consistent level of quality across the schemes. The registered manager had identified that some schemes had rated themselves as entirely compliant with audit scores of 100%. The registered manager planned to scrutinise these audits more closely and follow up with site visits as they were concerned these audits might not be accurate.

We recommend the service seeks and follows best practice guidance around the use of quality assurance mechanism to achieve consistency across multiple sites.