Creative Support Limited

Creative Support - Sue Starkey House & Shipton House

Inspection report

Sue Starkey House
6 West Arbour Street
London
E1 0FB

Tel: 07817460325
Website: www.creativesupport.co.uk

Date of inspection visit:
15 January 2018
16 January 2018
18 January 2018
19 January 2018

Date of publication:
14 March 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 15, 16, 18 and 19 January 2018. At our last inspection in October 2016 we rated this service "Requires Improvement". At this inspection we found that the service was now "Good".

Sue Starkey House and Shipton House provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People using the service lived in one of two blocks of flats in the London Borough of Tower Hamlets. Sue Starkey House consists of 32 self-contained single flats and eight double flats and Shipton House consists of 13 single flats. Both buildings have shared facilities such as a communal lounge and kitchen, laundry rooms and bathrooms and staff offices.

Not everyone using this service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection the service was providing personal care to 30 people, including older people and people with physical and learning disabilities.

The service had a registered manager, who was the provider's manager for the area. 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.

At our previous inspection we made a recommendation about how the service carried out checks of people's finances and the equipment that was used to provide care. There were now systems in place to make sure that equipment was safe and that finances were checked to protect people from loss or financial abuse. Managers had systems in place to ensure that staff understood what was required of them and communicated well, and checked that care was delivered as planned. Managers investigated and made changes when things had gone wrong.

People were supported to express their views about the service and managers took action accordingly. We saw that complaints were investigated and appropriate measures taken when these were upheld.

The provider had systems in place to safeguard people from abuse and avoidable harm, and had worked with the police and local authority to address current issues which may affect people's safety. We found that

people received their medicines safely, although audits did not always detect some problems with recording.

There were suitable numbers of staff on duty who were recruited in line with best practice. We found that at Sue Starkey House there was a high reliance on agency staff, and the provider was attempting to recruit new care workers to address this. People told us that staff were kind and treated them with respect; some people expressed concerns about staff skills in relation to cooking which managers were addressing through making information available and providing additional training. There were measures in place to make sure that care workers received essential training and managers checked they had the right skills and knowledge.

People's care was designed and delivered in a way which met their needs, but we found that care plans were not always clear about people's needs around continence. People received the right support to eat and drink and to stay well. There were varied and interesting activities programmes in place and this was a high organisational priority. We found that keyworking was not yet sufficiently developed to support people to express their views about how they received care and spent their time, but people's care was reviewed regularly. The provider notified us when allegations were made about people and when serious incidents had occurred.

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

There were measures in place to promote a safe service.

The provider operated effective measures to safeguard people from abuse and to learn when things had gone wrong.

Staffing levels were adequate to meet people's needs and appropriate pre-employment checks were carried out.

Medicines were safely managed and checked by staff.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and supervision to carry out their roles. There were measures in place to promote good health and ensure that people had enough to eat and drink.

People's needs were assessed as part of the support planning process and there was evidence that people had consented to their care.

Is the service caring?

Good

The service was caring.

People told us that staff treated them with kindness and respected their privacy. There were measures to promote and reflect on dignity.

People were supported to speak up, and there was evidence of this on people's plans including life story work.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was delivered as planned in line with people's needs. Care plans were reviewed regularly but sometimes did not always accurately describe the support people actually received.

There were detailed and imaginative activities programmes in place. Keyworking sessions were in the process of being implemented but were not yet fully effective.

Managers had processes for recording and investigating complaints and taking appropriate action in response to these.

Is the service well-led?

Good

The service was well led.

Managers had systems in place to ensure good communication and to clearly explain their expectations of care workers.

Care notes were audited to make sure care was delivered as planned. There were systems of engagement such as tenants meetings and surveys and the service listened to people's views and took action.

Creative Support - Sue Starkey House & Shipton House

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.

Why we inspected – We carried out this inspection because we had rated the service "Requires Improvement" 12 months previously. Since our last inspection the provider had notified us of eight incidents of alleged abuse. Of these, five were related to financial abuse; one was not substantiated and four related to abuse by third parties. One notification concerned a potentially serious medicines error, one was concerning the conduct of a member of staff and one concerned a person who fell in their room. The provider had informed us about their investigations and measures they had taken to prevent a recurrence. We were aware that a death had taken place in the service which was subject to independent review.

This inspection took place between 15 and 19 January 2018 and was unannounced on the first day. We visited Sue Starkey House on 15, 18 and 19 January and Shipton House on 16 January. The inspection was carried out by an adult social care inspector and an expert-by-experience on the first day and a single inspector on the remaining days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out this inspection we reviewed information we held about the service, such as information we had received from members of the public and notifications of serious incidents that the provider was required by law to tell us about. We asked the provider to complete a provider information return (PIR). This is a document which asks providers to tell us what they think is working well and their

plans to improve the service. We spoke with a monitoring officer from the local authority about their recent visit to the service.

In carrying out this inspection we spoke with five people who used the service and two relatives of people who used the service. We spoke with the registered manager, deputy manager, care co-ordinator, four care workers and a quality and practice development lead. We looked at records of care, including support plans and risk assessments for six people and checked medicines records for six people. We checked records relating to staffing, including recruitment, training, supervision and staff rotas, and looked at other information relating to the management of the service, such as audits, team meetings, complaints and health and safety checks.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe living there. Comments included "I do feel safe here", "All together, I like it here. I just feel safe in my own flat". People told us that staff helped them feel safe, this included one person who said "The staff are very trustworthy. They found money on my side table and left me a note to say they'd put it away in the drawer." Another person said, "They keep an eye on me and check on me regularly."

Care workers had received training in safeguarding adults as part of their induction, and those we spoke with understood their responsibilities to report suspected abuse. A care worker told us "Here it is taken very seriously." Where allegations of abuse had been made the provider reported these to the local authority and worked with them to manage these risks. This included a person who was being targeted by a person in the community, and we observed managers consulting with the police on how to address issues relating to visitors to the building. There was evidence that this was resulting in other people in the building also being targeted by people in the community, and the provider was working with the local authority to address this and was carrying out work with people on protecting them from financial exploitation. Where an allegation had been made about the behaviour of a staff member, this had been investigated by the provider and disciplinary action had been taken. Another safeguarding incident concerned a person who had fallen in their flat. An investigation of this had been carried out and the provider was arranging for a sensor to be installed to monitor their movements but in the meantime had introduced hourly checks in order to manage this risk.

There was an on call management system in place and a resident profile had been prepared for the out of hours service, this included a summary of people's medical needs and key information about their support needs and risks. There was also a missing person's procedure, which included a picture of the person and description and steps for care workers to follow if the person went missing. Where people were at a higher risk of going missing there was also information on places the person might go to.

There were risk assessments in place to support people to bathe or shower safely. This included information on whether people were able to get in and out of the bath and sit up, and whether they may not be able to recognise high water temperatures or summon help. For each person care workers kept a record that demonstrated they had checked the water temperature was safe before the person was supported to bathe; this included clear guidelines on what constituted a safe water temperature. The provider carried out risk assessments on whether people were at risk of falling, including looking at physical conditions and environmental factors, with clear plans in place for reducing this risk, and highlighting when people may be at increased risk of falling such as during cold and wet weather. Risk assessments also covered whether people had the capacity to understand risks to their safety and highlighted other areas such as self-neglect, alcohol abuse or risks from accessing the community without support. In one instance we saw that a person was bedbound. There were measures in place to manage the risks of pressure sores such as regular checks by the district nurse and repositioning the person in bed by the staff. The risk management plan for this person included how the person could be supported to move safely and how risks from health conditions were managed. The person had a hospital bed to manage this risk, but the plan lacked clear guidance for

staff on how often the person needed to be repositioned in order to mitigate the risk of skin breakdown.

People were able to call for help using pull cords and pendants where required. We saw that the provider checked these during spot checks and night staff carried out two hourly checks on different devices attached to the system in order to make sure the system was operational. People told us staff responded promptly to these. Comments included "There's call bells in all the rooms and they test them daily and do spot checks", "I've used it once or twice and the staff came within five minutes" and "You ring it and they come." We observed one person become unwell in a lounge area. Staff remained calm and offered appropriate support to the person and sat with them, offering reassurance until they felt better. The provider also had personal emergency evacuation plans (PEEPs) for each living in the service, these were kept up to date with information on people's mobility, health conditions and the support that they required to evacuate the building safely and whether the person was able to follow fire procedures.

There was a system of health and safety checks in place to maintain safety within the buildings. Spot checks were carried out on people's flats every two or three days, these included checking that people's flats were safe and free from hazards and checking that people's food was safely stored. There were weekly checks carried out of fire alarms and fire doors and monthly checks of firefighting equipment. There were up to date checks of gas and electrical safety and portable appliance testing. At Shipton House we found that routine flushing of vacant outlets had stopped in October, which meant there may be an increased risk of legionella; the provider commissioned a specialist company in order to address this and carry out an updated risk assessment. Access to the buildings was managed by key fobs and an intercom system, further locked internal doors led to where people's flats were and there was CCTV covering the entrances, and we saw examples of visitors to the service being asked to sign in and provide identification by staff.

At our previous inspection we made a recommendation about how the service carried out checks of hoists and lifting equipment and checked that money stored on behalf of people was stored safely. At this inspection we found the provider had acted on this recommendation. There was a list maintained of equipment including hoists and hospital beds and when these were last maintained, we saw that all of these checks were up to date. Records were kept of people's money, which showed that balances were checked by two staff daily and a fortnightly audit carried out by a senior member of staff. There was evidence that these audits had highlighted minor anomalies and appropriate action was taken in response to these. For each person there was a client finance form in place, which stated whether the person, their family or the provider had responsibility for a particular area of their finances, whether the person was subject to appointeeship or a Court of Protection order and details of the support provided in this area. The provider asked the local authority to apply for appointeeship where they were concerned a person could no longer manage their finances.

Staffing levels were adequate to meet people's needs. We saw that people received their support hours as planned, and there were measures in place to ensure this was the case. People told us they did not feel rushed during their care. Staff were arranged in a line system, whereby people's support hours and tasks were on a planner for each staff role, staff were then allocated a planner at the start of each shift. Staff told us they found this system effective and that usually there were enough staff on duty, but that at times they may be short due to people calling in sick. A care worker told us that when a staff role wasn't filled "We try to get cover but if not we have to work as a team and share the planner." Another care worker told us "We have a back-up plan to share the line, we have a gap in every line which will be used." We reviewed two weeks of rotas in each service and found that staffing levels were in line with what the provider described.

However, some people expressed concern that the front office at Sue Starkey House was not staffed at evenings and weekends and that there were not always staff in communal areas at this time. The provider

told us that they were not required to staff the front office continually, which we confirmed with the local authority. We saw that the issue had been discussed in tenants meetings; measures taken in response to this included having an additional activities co-ordinator on a Saturday and having managers provide additional cover at weekends; this remained in place but had reduced recently as there was not currently a service manager in place. We also found that there was a high reliance on agency care workers at Sue Starkey House; on four days over the past two weeks half or more of the care workers on duty were agency staff. The provider told us that they were in process of recruiting more staff for the service and we saw a job advertisement online.

There were measures in place to ensure that staff were suitable for their roles. This included obtaining a full work history, proof of identification and address and obtaining two references, including from a previous health and social care employer where relevant. The provider carried out a check with the Disclosure and Barring Service (DBS) before staff were appointed. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. Candidates were signed off by a director when the recruitment process was completed.

There were measures in place to ensure medicines were managed safely, but we found some instances where this could be improved. The provider carried out assessments on people's level of understanding and independence in key areas of medicines management, which was used to determine the level of support required. In some instances staff had not actually recorded the level of medicines support required, but this was clear from reading the document. Medicines assessments also highlighted when there were problems with people's concordance with their medicines. Medicines administration recording (MAR) charts were in place and care workers used this to sign in medicines and to record that medicines were given appropriately. The provider audited a sample of between seven to 10 MAR charts on a monthly basis, these audits showed that some issues such as gaps in the chart had been noted and a clear action plan was in place to address this. Daily logs required care workers to check that medicines had been given on the previous shift, which was also checked on spot checks, and we saw that on one occasion staff had noted an error on this check.

On one occasion a person's medicine had been changed and this had been handwritten onto the chart, however staff had continued signing for both medicines. The provider told us that this medicine was supplied in a blister pack so a mistake could not have occurred, but sent a memo to care workers reminding them not to handwrite medicines onto a MAR chart. When medicines were given on an "as needed" (PRN) basis, there were protocols for staff to follow, however one person had an emergency medicine which lacked a clear procedure. The provider subsequently obtained a clear flow chart from the pharmacist to highlight when this should be given and when emergency services should be called.

Staff received medicines training and managers undertook observations of competency before they were able to support people with their medicines. A care worker told us "I didn't start giving medication until I'd had the training, and then my team leader would come out and shadow me."

Where errors had occurred there was evidence of learning in response to these, which included carrying out further observations of a care worker's practice following a medicines error. A more serious medicines error occurred where one person received another person's medicines. The provider had sought medical advice for the person, and had investigated the causes of this error and had taken action to address these, such as purchasing a new medicines cabinet where people's medicines could be kept separately when stored in the office. They carried out "Golden Rules" training relating to safe medicines management and safeguarding for all care workers, who had also had additional medicines supervisions which tested staff understanding on recording, storage and the procedures to be followed. The provider had put an action plan in place

following the death of a service user which was subject to a serious case review. This included simplifying documentation, providing additional training to staff in areas of health support and capacity and adding discussion of people's health needs during handovers, which we saw was in place. Where incidents and accidents had taken place, these were recorded appropriately, and managers completed a form where they reviewed the incident. As a result of incidents, managers recorded ways in which it could have been prevented, and whether anything needed to change as a result.

People told us that care workers used appropriate personal protective equipment (PPE) as an infection control measure. Comments included "Yes, they wear aprons and gloves" and "All the staff here wear gloves." We saw that memos had been sent to the staff team about infection control procedures, including what constituted proper PPE, and how to maintain food hygiene and the proper and safe freezing and defrosting of food.

Good

Is the service effective?

Our findings

Staff received suitable training and supervision to carry out their roles. Staff induction included training around values, antidiscrimination policies, safeguarding and mental capacity and as part of induction staff were given a personal development plan and underwent shadowing. One care worker told us "I had a three day induction and I shadowed for two weeks, it was helpful". Care workers also received an in house induction, which included giving care workers and overview of people's needs and outlining expectations for handover and communication systems. There were measures in place to ensure that staff kept their core training in date, this included three yearly training in medicines, first aid, infection control and mental capacity, and two yearly training in manual handling. There was a training calendar in place in the staff room and we saw evidence of staff attending training to stay up to date with requirements.

People told us that they were happy with the skills of care workers, although some people told us that a particular concern they had was that some staff, especially agency staff, lacked cooking skills. For example, one person told us "They don't know how to boil a kettle" and another said "They need to give instructions to the staff on how to use an oven, a cooker and a microwave". We saw that this issue had been discussed at tenants meetings and in quality assurance monitoring; in response the provider had supplied staff with recipe sheets and guides to kitchen tasks such as using a microwave. The training officer also showed us training that they had prepared in response to this feedback in order to improve staff cooking skills.

Supervision was carried out three monthly, and included reviewing the previous action plan, discussing staff responsibilities in areas such as safeguarding and health and safety, and reviewing people's training needs before compiling an action plan. In addition to this the provider carried out themed supervisions where they assessed care worker's understanding and knowledge in areas such as medicines, safeguarding adults and dignity. There was evidence of follow up, for example one person's safeguarding supervision had been repeated as there had been gaps in their knowledge at the previous one.

People told us they received the right support to eat and drink. One person told us "They say [person's name] would you like this, and this?'" Another person said "They always ask me first. There's no point in having lunch if I'm not hungry and they come back later." People's plans showed the support they required with food, including when people were at risk of dehydration highlighting the need to provide certain food and drinks. Daily logs included details on the food people had been supported to have and these indicated a varied diet. One person's logs noted that staff had observed they had a dry mouth and were given drinks. Where a person was losing weight they had been referred to a dietician and supported to attend appointments. Care workers had recorded that the person had been supplied with the prescribed nutritional drinks, the person was subsequently discharged by the dietician as their weight had increased.

People were supported to maintain good health. Comments from people included "They help me to stay well by providing the regular drinks I need because of my condition" and "If there are any problems, they get a district nurse or GP in pretty quickly." People's health action plans contained important information about people's health needs including who helped them with certain areas of their support and how they kept healthy and active. In some cases these included clear measures such as to support people to use a walking

stick or maintain regular checks of a person's catheter, but in other cases these lacked clear objectives and outcomes. Resident profiles had information on people's mental health conditions, including how they affected the person. For example, one person's plan included information on when a person's mental health condition deteriorated, with detailed information on how to support the person to remain calm. Where concerns had been raised about a person's mental health staff supported the person to attend an appointment with a psychiatrist, and records were kept of other appointments people were supported to attend. Incident forms showed that people were supported to access healthcare in an emergency, and there was information for staff on alternatives to calling an ambulance in certain situations.

Where people were living with dementia, care workers had compiled information which could be taken with the person on hospital admission in order to provide information on how best to support them. This included information on what could worry or upset the person, what could make them feel better in this situation and how best to communicate with the person.

People's needs were assessed as part of the support planning process. Support plans highlighted what peoples' needs were, as well as a desired outcome, in a broad range of areas. These included those relating to physical and mental health, mobility, personal care and daily living skills.

Consent to care was obtained in line with the Mental Capacity Act (2005) (MCA). The Act 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 had signed their plans to show that they had consented to them, and when people were unable to sign due to physical reasons the provider had stated why and had demonstrated the person had verbally consented to their care. Where there were orders such as those from the Court of Protection around people's finances, there were copies of these and appointeeship orders on people's files to ensure that staff were working in line with these. The provider routinely conducted an assessment of restrictions and potential deprivations of a person's liberty to ensure that their rights were protected, this included assessing whether the person could consent to a potential restriction, such as constant supervision or being unable to leave the building without an escort, and whether a best interests decision was required on behalf of the person.

Good

Is the service caring?

Our findings

People we spoke with were positive about the caring nature of their care workers. Comments included "I'm looked after well" and "I get on well with the staff…one is like a sister to me" and "They do [treat me with respect] and I treat them back with respect."

Staff told us they valued the people they worked with. One carer worker told us, "I'm very close to the service users" and another said, "We have the time to chat with them. I'm really happy when I'm sitting with them." We saw examples of respectful interaction and care workers taking the time to talk to people and respond to problems. For example, one person's mobility scooter had broken down, and staff noted this and went to offer support. People were greeted in the lounge when they entered and addressed by their chosen names. We saw an example of a person coming to the kitchen to chat with a member of staff who seemed to know them well.

There were systems in place to support people to express their views. For example, people had personal profiles which included personalised information about the person, what they liked and disliked and what was important to them, their preferences regarding their support and preferred gender of support workers. At Shipton House the provider had carried out detailed life story work which included information about people's childhoods, working lives, significant relationships and people's preferred names. We saw that daily logs had reported people's views on their care, such as whether they wanted support that day, what they wanted support with and whether people chose to engage with activities, which was respected by care workers. Care workers we spoke with gave examples on when they had supported people in line with their culture, including times they had learnt something new about a person's culture from the requests they had made of staff.

People's privacy was respected. Comments from people included "They're very good and respect my privacy, no worries there", and "They always ring the doorbell, they never walk in. They do respect your privacy" and "They always ask your permission."

There was a good level of leadership around promoting people's dignity. In each service there was a display called a dignity tree, which included a pledge from the provider to treat people with dignity, people using the service had provided their thoughts and experiences on what it meant to be treated with dignity. Managers had sent memos to staff outlining their expectations around dignity and privacy, which included knocking on doors and communicating well with people. Staff also undertook a yearly "Dignity Challenge" supervision, which discussed people's rights to privacy and discussed the meaning of a zero tolerance approach to abuse. Staff were encouraged to reflect on times they had treated people as individuals and to compile a 'dignity action plan' to improve their practice in this area.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us that staff were able to meet their needs. One person told us, "The staff know exactly what I want and how I want it done."

People's care was planned and delivered in a way which met their needs, but some care plans needed review to reflect changes in people's needs. People's care plans were structured in a way that identified particular care needs and a desired outcome. This was arranged around areas of care such as personal care, skin care, daily living and routine, health needs, and social needs including activities. Plans were used to draw up a visit summary list, including the tasks and support people needed at these visits. This was then used to draw up staff daily planners so that people received care as planned. We reviewed people's care logs and saw that people received care as planned. Care workers had signed people's plans to indicate that they had read and understood them.

There was evidence of responsive care. For example, staff were recording whether people were in a low mood and the level of support they had provided based on this. At other times care workers had indicated that they had not needed to provide care as a person had already done this for themselves. For some other people we saw that extra hours of care were provided based on how the person was, for example one person's log showed that staff had stayed with them for a much longer period of time as they were in a low mood and frequently upset. Another person received additional support at the request of their partner who was going to be away for a period of time. Where people required checks at night this was clearly recorded on plans and care workers recorded the time that they had visited in line with this, and how the person was including whether they were asleep.

We found two instances where plans no longer accurately reflected the support people received with continence. For example, one person's plan stated that they needed regular help to manage a catheter, but daily logs showed that this was no longer in place and that actually staff supported them to change an incontinence pad. For another person, staff had recorded they had regularly supported them with an incontinence pad however this was not referred to on the plan, but the plan did make clear that the person was very independent and would inform staff of what needed to be done. However, it was clear that the provider was meeting people's needs where continence support was in the plan. For example, one person's plan stated that staff were required to check their catheter and change the pad on a daily basis, and care workers recorded this appropriately.

People received regular reviews which took place at least yearly. Reviews were used to record any issues of concern, whether a person was making progress in their health and daily living skills and any changes in their needs or problems with their care package. In one case a person had been reluctant to engage with any care workers at all, the provider used the review to record which care workers they were happy with and agreed that the person would only be supported by those care staff; which was also clearly marked on allocation sheets. Where people had requested additional time there was evidence that this was explored further and put in place when agreed by the local authority. We found examples of people being presented with information in a format applicable to them, for example one person had information about the use of

the kitchen supplied in their preferred language, and there was simple information on how to complain and keep safe displayed in the service. However, people's support plans and reviews were not supplied in an accessible format which meant they could be hard for people to understand fully, and it was not always clear from assessments whether specific accessibility formats were required for people.

We found that there were keyworking measures in place, but the application of these was sometimes limited. At Shipton House keyworking sessions took place every three months, this reviewed people's support in line with their plans. However we found that sometimes this involved simply describing the support people received in a certain area without reference to recent changes or challenges. In some cases people's views on their care were not recorded, however we found that these always included a list of agreed actions, such as new things the person wanted to try or appointments they would need support to attend. This included a person who informed care workers that they wanted to learn how to read, and had received support to attend a local library service.

At Sue Starkey House keyworking had not yet been established on a regular basis, however the provider had recently allocated keyworkers to people and had a scheduled of planned keyworking sessions. Senior staff had started to consult with people on what they hoped to achieve from keyworking with a clear list of areas for the keyworker to consider in discussions, although only three of these had been completed at the time of our inspection. There was evidence that staff had consulted with people to set goals such as improved daily living skills, engagement with activities and access to the community, which was recorded on the keyworking file.

People using the service had access to a varied and interesting activities programme which was an organisational priority. Comments included, "They encourage you (to participate)" and "The activities (co-ordinators) are very nice, they're all young and earnest." The provider told us that due to changes in their contract they would have access to more hours for activities.

There was evidence of activities taking place in both services. For example, the hairdressing room at Sue Starkey House was now being used as an art room, we saw this in use during our inspection and it was decorated with pictures made by the art group. There was also a library at Sue Starkey House which doubled as an activities and darts rooms. The activities programme included weekly gardening, a shared takeaway, quiz, darts, board games and arts and crafts. There were also special sessions around occasions such as Chinese New Year, Pancake Day, Christmas and trips to local markets.

At Shipton House, there were resources for activities in the main lounge, which included large playing cards for playing "Higher or Lower" and information on local community groups. In the garden there were activity boards which had been made by volunteers, for example with household tools and locks. We observed a weekday "knit and natter" group; as people came into the lounge from the nearby day centre staff had cups of tea ready for people and engaged them with activities such as nail care and knitting. Weekly activities included a shared brunch and Sunday roast, reading groups, reminiscence themed activities and chair based exercises. There were seasonal themed activities including special events for Halloween and Christmas. The provider had consulted with people to discuss their involvement in upcoming events and activities that they would like to do.

There was a complaints recording system in place. At Shipton House there had not been any complaints made since the last inspection, but a survey had highlighted that people weren't always clear on how to make complaints; in response to this managers had installed a complaints box and worked with people to explain the complaints process. At Sue Starkey House we saw that complaints were addressed. This included taking action to address problems with the maintenance of the building, and as a result had

arranged for a local contractor to visit weekly to address minor issues. In response to a complaint about staff cooking skills they had taken action to address this, such as preparing cooking guides for staff and were planning additional training. Where staff had made mistakes, such as one instance where they had accidentally turned off a person's freezer, the provider had apologised for the mistake and offered compensation for any losses suffered.

Good

Is the service well-led?

Our findings

Since our last inspection we found that both site managers for Sue Starkey House and Shipton House had left the service and the provider was in the process of recruiting new managers. However, there remained clear management systems in place, and the registered manager and other managers in the area were providing support to the interim managers. A new manager had started work at Sue Starkey House soon after our inspection. People who used the service and their relatives were positive about the management arrangements. With regards to one of the interim managers a relative told us, "The manager now seems very good and organised. I noticed when I give her a letter she takes a copy and staples it to the diary."

There were clear systems in place for promoting good communication amongst the staff team. We observed a handover taking place between care workers, this included handing over any tasks that were outstanding, information about who was unwell and information about who had left the service and when; this was recorded in a handover sheet and information about people was recorded in a communication book. These were completed by staff and signed off to ensure that they were completed correctly. Care workers we spoke with were positive about how communication was maintained, with comments including, "We do a handover of anything that is not done and why" and "In care the most important thing is communication."

We noted on our arrival there was a board listing which care workers were allocated to each "Line", this corresponded to a clear allocation system for what needed to be done and by who. Allocation sheets included information on what tasks people needed support with, what they will do for themselves, and checking what needed to be carried out, such as checking whether a particular person had taken their medicines. A care worker told us, "It is very easy to deliver a service here; the system is perfect" and another said, "We work as a team here, we look after our clients very well."

There were systems in place to communicate with care workers and clearly outline the expectations of managers. For example, team meetings took place every two months and were used to discuss areas such as policies and procedures, including those relating to health and safety, and how spot checks were to be carried out, including checks of people's pull chords. There was also a record of memos sent out to staff; this included a list of people where staff had to record that they had no contact with the person, recording of financial transactions in line with our previous recommendation in this area and the need to ensure that people's flats were kept clean. Managers had highlighted a high number of 999 calls, and had sent information to care workers on alternative ways of dealing with specific incidents and outlining when calling an ambulance might not be necessary. For example when this could be addressed through calling NHS 111 services.

Managers carried out monthly audits of people's care notes, including checking whether recording was clear, whether care workers had commented on people's welfare and the support they received and whether times were in line with people's care plans. There was evidence of follow up; for example one person's notes in October 2017 had not routinely recorded that they had received continence care, this had been noted by managers and discussed with care workers, and this was now being recorded correctly. There were robust systems in place to monitor staff skills and understanding in key areas, such as themed

supervisions around dignity, medicines and safeguarding adults. Care workers were also encouraged to reflect on their practice and how this was delivered in line with our key lines of enquiry, and had recorded examples of when they thought they had delivered a service that was, for example, safe or responsive.

People told us that the service engaged them to express their views through surveys and regular meetings. Comments included, "There's a meeting every fortnight, you can speak your mind", "They do the surveys every year and there's minutes from the meetings", "You get a form twice a year. One of the staff does it, they come round and talk to you." Tenants meetings were used to discuss issues affecting the service such as changes in management, repairs arrangements and obtaining people's views on their care. There was evidence that managers responded to this, for example by arranging for minor repairs to be carried out by the provider on a weekly basis, arranging the cleaning of the lounge in response to concerns about odour and implementing a rota for management cover at weekends. Similarly a survey had recently been carried out by the provider to get people's views on their care; we saw that feedback from this was almost entirely positive, but where a small number of people had expressed concerns managers had drawn up an action plan in order to address these.

The provider was displaying its registration certificates and ratings from their previous inspection at the service, and we saw that these were also displayed on their website. We found that the provider had notified us of serious incidents and allegations of abuse and had kept us informed of ongoing concerns; this included an ongoing case of financial exploitation and a person who regularly went missing from the service.