Joseph Rowntree Housing Trust

JRHT- Independent Living Services

Inspection report

The Oaks Hartrigg Oaks
New Earswick
York
North Yorkshire
YO32 4DS

Tel: 01904735034

Date of inspection visit:
22 March 2016

Date of publication:
28 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an announced comprehensive inspection on Tuesday 22 March 2016. We gave the provider 48 hours' notice of our intention to undertake an inspection. This was because the organisation provides a domiciliary care service and we needed to be sure that someone would be at the agency office that could assist us with the inspection. This service was registered by CQC on 22 August 2014 and this was the first inspection for this location.

Joseph Rowntree Trust Independent Living Service provides care and support to people in six properties across York and the surrounding areas. People hold their own tenancy agreements and there was a mix of individual and shared accommodation across the scheme. The service is registered to provide personal care for people with a range of varying needs including, learning disabilities or autistic spectrum disorder, older people, sensory impairment and younger people who live in their own homes. At the time of our inspection, 19 people received a personal care service. The service provides community based care and support services from the registered office location, on the outskirts of York.

The registered provider is required to have a registered manager in post and on the day of this inspection, there was a registered manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People who used the service told us they felt safe and we found that care workers had received training in safeguarding people from abuse and knew how to protect people from avoidable harm. Care files contained up to date risk assessments that helped promote people to maintain their independence in a safe way. Risk management plans were in place and they were regularly reviewed and updated in line with the person's needs.

People's care files were thorough and focused on the person. Care plans included an easy read version and a section, 'What's Important to Me'. This recorded personal history, personal preferences, interests and aspirations of people. We saw this helped care workers to deliver personalised care for all areas of a person's life.

We saw that accidents and incidents were recorded. These were logged monthly onto a quality assurance system where they were investigated and analysed by the health and safety officer. Because of these investigations, the registered provider had implemented risk assessments and had updated support plans.

The registered provider undertook a variety of recruitment checks to help ensure care workers recruited were considered suitable to work with vulnerable people. We saw care workers underwent an induction programme to gain a fundamental understanding of providing care for people that included areas of mandatory training. Care workers received training in privacy, dignity and confidentiality during their

induction. We saw that the registered provider undertook documented observations on care workers whilst they delivered care and support to people to ensure they upheld the basic values of care. The induction was followed by a period of shadowing experienced care workers until the care worker was signed as competent to provide care and support on their own.

People and care workers raised concerns around the use of agency staff. The registered manager told us they had an action plan in place to recruit permanent care workers and appropriate checks were carried out when agency staff were used. The registered provider recognised the importance of building relationships between people and the carers and told us they had involved people in the recruitment process.

The registered provider had a medication policy and procedure in place and this followed guidance provided by 'The National Institute for Health and Care Excellence' (NICE). We saw this was reviewed and updated at least annually. There was clear guidance for people who were prescribed 'as and when needed' (P.R.N) medication and appropriate guidance by way of pictorial body maps was documented for the application of patches, creams and emollients. Appropriate risk assessments were completed and training provided to care workers to help them to ensure that they followed the agencies policies and procedures.

Care workers had received training and understood the requirements of The Mental Capacity Act 2005.

The registered manager showed us maintenance certificates for the premises, which included the electrical wiring certificate, gas safety certificate and portable appliance checks. These were up to date and helped to ensure the safety of the premises. We saw regular maintenance programmes in place. This meant the environment was safe for people and others.

We saw people were kept safe from the risk of emergencies in their home. People had a risk assessment in their care files for the environment and a personal emergency evacuation plan (PEEP). PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation taking place.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST'). These were completed monthly and where risks were identified, we saw the person's care and support plan had been updated.

We saw peoples dietary requirements noted in their care plans that included details of food likes, including any religious dietary requirements and information on supporting people with good nutrition and hydration. The support people received varied dependent on their individual circumstances. Appropriate professional advice was identified where necessary to ensure people's health needs were supported.

Care workers told us they felt well supported and we saw good communication and relationships between care workers, management, people who used the service and outside agencies such as the local authority and health workers.

We received positive feedback about the leadership and there was a high degree of confidence in how the service was run. Care workers we spoke with told us the registered manager was approachable open and honest. Management understood how to meet the conditions of their registration with the Care Quality Commission (CQC).

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and were protected against the risks of bullying and harassment.

Care workers had received training in safeguarding adults and understood the signs of abuse to look out for and how to report any concerns.

People raised concerns around the use of agency staff but we saw sufficient numbers of care workers who had the skills and knowledge to support them supported them.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by care workers who had access to training and courses to meet people's needs.

Care workers we spoke with understood the importance of ensuring people consented to the care and support they provided and had an understanding of the Mental Capacity Act 2005.

People were supported with their dietary needs and helped to maintain a balanced diet. People at risk of losing weight were closely monitored and supported from multiagency teams.

Is the service caring?

Good

The service was caring.

We observed the service provided person centred care. It was clear the care workers had an understanding of people's needs and preferences and put their needs first.

Privacy and dignity was consistently maintained and care workers were respectful when providing care and support to

people.

People were encouraged to be independent and were supported to make their own choices wherever possible.

Is the service responsive?

Good

The service was responsive.

Care records were detailed, person centred, and people received individualised care and support which reflected their personal preferences and lifestyle choices.

People knew how to complain. Compliments and complaints were encouraged and responded to.

People's views and opinions were sought in a variety of ways and their ideas and suggestions were responded to.

Is the service well-led?

Good

The service was well-led.

Care workers told us the service was well managed with open communication creating a positive culture.

Quality assurance processes monitored the service provided to make positive improvements to benefit people's experiences of care.

People's views and feedback was sought and people told us that if they raised issues they were dealt with appropriately.

There was a clear management structure in place and care workers understood their roles and responsibilities.

JRHT- Independent Living Services

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.

The inspection took place on the 22 March 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

One adult social care inspector undertook the inspection. Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider. The registered provider submitted a provider information return (PIR) prior to the inspection. 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 spent time with three people receiving services in their own home. We interviewed four care workers and we spoke with the registered manager and the quality compliance lead. We looked at records, which related to people's individual care; this included the care planning documentation for four people and other records associated with running a community care service. We also looked at six care workers recruitment and training records, the care worker rotas, records of audits, policies and procedures and records of meetings and other documentation involved in the running of a domiciliary care agency.

Good

Is the service safe?

Our findings

People receiving a service were protected against the risks of potential abuse and bullying. People confirmed they felt safe. One person told us, "They [care workers] are very good, I do feel safe." We saw care workers received up to date training in safeguarding vulnerable adults and they discussed with us what signs of abuse they looked out for and what they would do if they had any concerns about people's safety. One care worker said, "I have had safeguarding and whistle blowing training." They told us, "I would report any concerns without a second thought as I know my confidentiality would be respected and concerns would be acted on." Care workers had access to a comprehensive policy and procedure about safeguarding adults from abuse and these were written in conjunction with the local authority procedures for safeguarding adults from abuse.

We looked at people's care plans and we saw that these provided consistent up to date information about their care and support needs including associated risk assessments and support plans. We saw people's independence was supported and respected using risk assessments to identify and work within the capacity of the individual to undertake daily activities in a safe way. One person had the use of a vehicle due to reduced mobility; we saw a comprehensive risk assessment in place with an associated support plan. Care workers told us they had undertaken people handling training and we saw documented practical skills assessments were completed. This ensured care workers had the information and competency to transfer the person to the vehicle safely.

Risk assessments were in place for falls, infection control, and administering of medication. These were reviewed and updated with the involvement of people, families and professionals and helped to keep people safe and promoted independent living.

We saw that accidents and incidents were recorded. These were logged monthly onto a quality assurance system where they were investigated and analysed by the health and safety officer. Because of these investigations, the registered provider had implemented risk assessments and had updated support plans. We saw evidence that risks were managed using input from other health professionals such as a physiotherapist and occupational therapist and that additional aids and adaptions were accessed to help prevent re-occurrence and to help keep people safe.

People told us that care and support was provided by regular care workers but some people and care workers raised concerns regarding the use of agency staff. One person told us, "We have regular care workers, which is great as they understand me," they continued, "It can be difficult with agency staff." A care worker told us, "I like it when we have full time care workers who you can trust and leave alone to get on with their jobs," and "It's harder when we have agency staff as we constantly have to shadow-shift them to make sure they are doing things right." We asked the registered manager about this and they told us they were aware of the concerns. They told us, "We have an action plan in place to reduce the use of agency but where this is required, regular workers are requested." We saw the registered provider had a file with profile details of agency staff that included their name, base, suitability checks, references and training they had completed.

We looked at the recruitment files for five care workers. We saw that the dates were recorded for when references and Disclosure and Barring Services (DBS) checks had been received. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The registered manager advised us that care workers shadowed experienced workers and had recruitment checks in place before being allowed to work independently. It was clear that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. A care worker said, "The recruitment process is robust, we can't start to work with people until all our checks are back and ok." This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

The registered provider had a medication policy and procedure in place and this followed guidance provided by 'The National Institute for Health and Care Excellence' (NICE). We saw this was reviewed and updated at least annually. We saw changes were communicated and discussed with care workers at staff meetings and care workers were required to sign to say they understood any changes. Care workers told us additional training was provided when appropriate. We looked at care workers files and saw care workers involved with medication received appropriate up to date training. Monthly documented competency checks were recorded and included observations on care workers administering and recording medication to ensure they remained competent in the process.

The registered provider told us on their Provider Information Return (PIR), 'Medication management is only provided following an individual risk assessment to ensure that it is tailored to the individual's needs.' We saw that peoples care files contained risk assessments to assess what level of support they required with their medicines. Where people needed support we saw that information including the type and frequency of medication was detailed on support plans and that these were regularly reviewed. Medication was kept in locked cabinets in people's accommodation. We looked at Medication Administration Records (MAR), we saw that these were completed appropriately to evidence when medication had been administered.

The registered manager showed us guidance to help them provide a framework for decision making about consequences for care workers who made medication errors. We saw care workers errors with medication were scored against the possible impact on the health and well-being of the person. Once three or more points were achieved, care workers undertook supervision with an assessor and additional training was undertaken. The care worker was not allowed to administer medication until deemed competent and they had received additional spot checks. This process helped to ensure people received their medication in a safe and controlled way by competent care workers.

There was clear guidance for people who were prescribed 'as and when needed' (P.R.N) medication and appropriate guidance by way of pictorial body maps was documented for the application of patches, creams and emollients. One person we spoke with said that they required minimal support with their medication. They told us care workers helped them get the medication out of the packet but that they themselves made sure stocks were up to date and recorded appropriately. Another person required full support and this was clearly documented both in their care file and on their MAR.

We saw people were kept safe from the risk of emergencies. People had a risk assessment in their care files for the environment. These included personal emergency evacuation plans (PEEP). PEEPs are documents, which advise of the support people need to leave their home in the event of an evacuation taking place.

The registered provider undertook regular environment checks. We saw fire safety risk assessments were in place and up to date. These included the weekly recording of fire alarm tests and checks on emergency lighting and fire extinguishers. Care workers told us and we saw from their files that they had received up to

date training in fire safety at work.

Care workers we spoke with understood the importance of their roles and responsibilities in maintaining high standards of cleanliness and hygiene. The registered provider had policies and procedures in place and we saw that care workers had received training in health and safety in the home, infection control and food safety. We observed care workers using personal protective equipment (PPE) such as aprons and gloves during our inspection.

Weekly health and safety checks were documented and maintenance and service contracts were in place and up to date on equipment for moving and handling of people and specialist tilt baths. We saw details of premises checks including gas certificates, cable system certificates, portable appliance testing, and showerhead checks were completed and were all up to date. The registered provider had a risk assessment and logbook that documented up to date checks for legionella bacteria by an external contractor. Maintenance programmes were in place and the registered provider had the use of an internal maintenance team. These were all up to date and helped to ensure that the registered provider had taken steps to ensure that premises and equipment were managed to keep people safe.

Good

Is the service effective?

Our findings

People told us that the service was effective and that care workers understood their needs. The registered manager said, "Wherever possible people are allocated a key worker to undertake key areas of care such as medication and activities such as shopping and visiting the doctors." Care workers and people using the service told us the registered provider was actively recruiting new care workers with some interviews being held the week after our inspection. The registered manager told us, "Recruitment is an important process; we need to ensure we get it right and employ the right care workers to meet people's needs." They said, "People are involved with the recruitment process, this helps to ensure care workers are a suitable match for people."

People spoke highly of the care workers delivering care. A person told us, "They all seem to be good care workers, I have no concerns." Another told us, "We are told who is coming and they [care workers] write it on the white board so we don't forget." A care worker told us, "It feels like a family, we all look after each other." They said, "We have lots of time to spend with people on a one to one basis which is great."

The care workers we spoke with told us that they received an induction when they began work. They told us that they attended a corporate induction over the first week before shadowing existing care workers before working on their own. A care worker told us, "The induction was great, it provided information and skills I needed to start work" they continued, "The shadowing period lasts a minimum of two weeks but I had it extended, it depends on the individual and how competent they become" and "It helped me get to know people and their needs." All new care workers were enrolled on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. It assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care.

We saw care workers undertook a structured probationary period after completion of their induction. This included a documented progress review where any outstanding objectives were recorded and achievement dates scheduled.

The registered provider told us on the PIR, 'There is an ongoing training plan to ensure mandatory training is maintained and in addition optional training is offered in line with resident need.' We saw care workers had access to an electronic database of learning via a unique access that recorded their activity and outcomes. The system enabled the registered provider to ensure care workers had undertaken all mandatory training and that refresher training was scheduled and undertaken.

We looked at training records for six care workers. Training was a mixture of on line and e-learning and included equality and diversity, first aid, safeguarding, manual handling, medication, fire safety, food hygiene, health and safety, dementia awareness, person centred approaches, nutrition and hydration, infection control, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw person specific training was available to care workers. One care worker file we looked at showed they had completed training in Parkinson's disease, continence and epilepsy awareness. A care worker told us, "There

is always some training available and the manager will source additional training if it's not already available so we can look after people and meet their individual needs."

We saw care workers had their competency checked after undertaking training. We saw moving and handling people learning was followed up with practical skills assessments and this was recorded. Where competencies had not been achieved, additional training was provided. This meant that their knowledge and skills were kept up to date and that care workers were competent in delivering care and support to people.

The registered provider undertook quarterly one to one and observed supervisions with care workers and we saw these resulted in an annual review that included support with personal development. One care worker said, "I have regular meetings where we discuss my performance and any training needs." This meant care workers received effective support, induction, supervision, appraisal and training to support and care for people.

Care workers had received training and understood the requirements of The Mental Capacity Act 2005. A care worker said, "We encourage people to make their own decisions." 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 spoke with the registered manager who told us peoples risk assessments and care plans were continually reviewed and updated as people's needs changed. They told us and we saw where they had concerns that people's needs had changed resulting in a reduced capacity to make particular decisions they had commenced applications for further assessments in line with the MCA.

We asked management and care workers how they managed anxious behaviour by people. The registered manager told us "We avoid restraint and use de-escalation techniques in line with policy and procedure." A care worker told us, "We don't restrain people, their behaviour patterns are documented in their care plans, and we often just need to be patient." We saw where required, that care workers received training in managing people that displayed anxious behaviour.

We saw peoples dietary requirements noted in their care plans that included details of food likes, any religious dietary requirements and information on supporting people with good nutrition and hydration. The support people received varied dependent on their individual circumstances. One person told us, "I don't have any dietary requirements." Another said, "They [care workers] have helped me prepare a menu and we do the shopping list together," they added, "I am involved with the cooking too; care workers just help me out with some difficult bits." A care worker told us, "I ask [Name] what they want and make recommendations, it's their choice," they continued, "If I had concerns about a person's health I would discuss with the senior and we may refer them to a dietician or a GP." This helped to ensure that people gained sufficient support with eating and drinking to maintain a balanced diet.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST'). These were completed monthly and where risks were identified, we saw the person's care and support plan had been updated.

We saw care plans contained a record of medical appointments and an individualised 'Health Action Plan' that identified a person's daily care needs. These included general health, exercise, weight and skin integrity plans. We saw these were reviewed at least monthly and as appropriate involved documented multi discipline team visits to help support and care for people. Where people's needs changed quickly we saw the registered provider had made referrals to and we saw people had access to a range of health professionals and these included opticians, doctors, occupational health staff, physiotherapists and others. This meant care workers understood people's needs and the registered provider had ensured processes were in place and information was available to ensure people's day-to-day health needs were met.

We were shown around people's accommodation with their permission. People told us they had been involved with the decoration choices in their bedrooms. Bedrooms were designed to allow people to navigate with their personal equipment. Double doors provided people with access to outdoor spaces and the car park where there was adequate space for people to manoeuvre and access their vehicles. The design of the accommodation encouraged and promoted people's independence ensuring their mobility was provided for.

Good

Is the service caring?

Our findings

During the inspection, we observed that care workers knew the people they cared for and that they understood how to treat them with dignity and respect. People were addressed in the way they wanted to be and we saw they responded in a positive manner when spoken to. We asked care workers how they got to know people's likes, history and their preferences. One care worker told us, "I have worked with [Name] for a long time, it's like a big family." Another told us, "It's about building up a relationship with people, we are lucky we have lots of time to spend with people." Another told us, "Information about people is available in their care plans, and that information is kept up to date."

All care workers attended an induction followed by a minimum period of two weeks shadowing experienced care workers. This meant new care workers and people got to know each other whilst people were supported by care workers that already knew then. Experienced care workers ensured that new care workers and people were matched. We were told that people were regularly asked if they were happy with their care worker and if they were not arrangements were made to ensure people received care from the most appropriate person to meet their needs.

People told us they were happy with their care and that they knew their key worker. A person told us, "[Name] is so caring, they really help me, I wouldn't be able to go on holiday without them." Another told us, "I have a regular carer, if I have an appointment I go with them and not someone I don't know quite as well." The registered provider told us on the PIR, 'We use a key worker system to ensure that every person we support has a well matched key worker who can play a full role in planning and reviewing the individual's service.'

Discussions with care workers revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We saw from the minutes of a recent tenants meeting that some people had religious needs and there was information about those beliefs for those people. We saw these were adequately provided for within the service and by people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care workers we spoke with told us that people, their families and advocates were involved with their care and support planning. They said, "We regularly speak with family members and invite them to meetings with the person and their key worker." We saw from care files that there was good documented communication between the registered provider, people, their families and other health professionals. People told us their views were listened to and that they were involved with developing their own care plan and that it met with their needs.

We saw from care plans that where people did not have full capacity or were unable to express their views they were provided with information and assisted to make a referral to an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to

access information and services to promote their rights and responsibilities. The registered provider told us that two people receiving a care service were members of 'York People First' advocacy Group. One person we spoke with told us the group met every six months and that they were able to promote their views and those of people with Learning Disabilities.

Care workers received training in privacy, dignity and confidentiality during their induction. We saw that the registered provider undertook documented observations on care workers whilst they delivered care and support to people to ensure they upheld the basic values of care. A care worker told us, "We receive on the job observations and the outcome is discussed at the follow up supervisions to ensure we are working with best practice approaches and that people are happy with us."

A care worker we asked told us how they maintained people's privacy at bathing time using towels to keep them covered and that they made sure curtains and doors were closed. They discussed how they communicated with people to ensure people understood the care they received and that they agreed with it. The registered provider told us on the PIR, 'All of our residents are supported within their own homes, there are policy and guidance documents about the behaviour and attitudes that are expected by care workers and this includes the right for friends and family to visit.' We observed care workers knocked and waited for permission before entering people's homes.

The registered provider told us on the PIR, 'People's preferences and choices for end of life care is discussed with them and their families and documented in their care and support plan.' We looked at care and support plans and did not see evidence that this was documented. We spoked with the registered manager about this and how they supported people's to make their preferences for end of life care known. The registered manager told us they were reviewing the process and were updating care and support files to include people's preferences and to ensure choices for their end of life care were clearly recorded, communicated, kept under review and acted on. They told us, 'The palliative care team support staff, residents and families when a terminal diagnosis has been made.' We saw the home worked with palliative care services including Macmillan nurses and the Hospice. Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses. This meant people were supported at the end of their life to have a comfortable, dignified and pain free death.

People we spoke with told us there were no restrictions on visitors to the service. One person told us, "My sister visits whenever she wants to." Another told us, "My family is always visiting including my niece who I like to see often."

Good

Is the service responsive?

Our findings

People told us that they were involved in discussions regarding their care. People confirmed that the care delivered was responsive to their changing needs. We looked at people's care files and we saw they were thorough and focused on the person. Care plans included an easy read version and a section, 'What's Important to Me'. This recorded personal history, personal preferences, interests and aspirations of people. We saw this helped care workers to deliver personalised care for all areas of a person's life. In a care plan, we looked at how a person had responded to a question; 'What do you want staff to do when they visit?' The person had written, 'Knock and wait to come in.'

We saw people's care files contained a planned weekly timetable. These provided an overview of the person's needs and preferences for the week ahead and included personalised care such as one to one sessions and shopping activities. One diary noted, 'I go to pastimes on a Monday and Thursday during the day' and 'I have one to one hours on Friday between 10am-4pm.'

Care files contained an easy read formatted care and support overview. These had been completed with input from people and as appropriate their families and other health professionals. The overview provided a quick reference to people's choices and preferences which included their personal care, communication, finances, health/ medical conditions, medication, mental health/behaviour, mobility and movement, nutrition, relationships, daily living and work/leisure time care and support.

We saw one person had documented their mobility needs stating, 'I am mobile and can walk short distances unaided, however on longer distances I have a wheelchair and a car for mobility' the plan continued, 'I should be encouraged to walk as much as possible.'

We saw these documents were followed by detailed support plans for each area of personal care. People's care needs were regularly reviewed and people signed their agreement to their care records. The registered provider told us on the PIR, 'They [care plans] are reviewed regularly to ensure that they reflect [people's] current needs.' And 'During this review people are encouraged to tell us what changes they would like in support of their wishes.' The registered manager told us, "At times such as the annual review of care for people, we engage with the local authority, other health professionals and we invite family members to ensure we have a holistic care plan in place to meet a person's full needs."

People told us that care workers were flexible and would always try to accommodate any particular social opportunities that included activities or health appointments. The registered provider told us, "An example of this is when a resident wanted to change his support hours to suit his weekly activities." They said, "Specifically the person wanted to move shifts from the weekend to cover activities on a Tuesday and Thursday to ensure they had support for meals and personal care."

Care workers were knowledgeable about the people they supported. They were aware of their interests and personal preferences as well as their care and support needs. Care workers discussed how the service reacted to people's changing needs; a care worker told us, "[Name] had been bed bound after suffering a

fall," they continued, "This made them anxious about walking again so we engaged an advocate and an occupational therapist and tried some new routines to ensure the person did not suffer any isolation." As a result, we were told the person did not suffer unnecessary social isolation and had regained their mobility.

People were encouraged to offer feedback, share their experiences or raise any concerns. The registered manager showed us the results of an annual survey sent out to people receiving services. We saw 100% of people had participated. Responses showed 89% agreed that care treatment and support was available when needed and 11% neither agreed nor disagreed. 68% of respondents thought they had a real say regarding how care workers provided care and support, 21% neither agreed nor disagreed and 11% disagreed. Comments included a perceived lack of involvement by the registered manager at the service and a lack of consultation when changes occur. We spoke with the registered manager about the feedback and comments raised, they told us the survey had just been completed and they were in the process of evaluating and responding to the findings. A care worker we spoke with told us, "The resident surveys certainly improve the service for people.' Another said, "We always update care plans when people provide feedback, to make sure we are providing them with the best care."

The registered provider had a complaints procedure in place and care workers we spoke with were clear of the importance of reporting and recording any complaints. One care worker told us "I would report any complaints direct to the senior care worker or the registered manager." The registered manager told us details of complaints and a summary of the action was collated centrally and discussed by senior management. We saw feedback was then discussed at weekly management meetings and lessons learnt were documented on weekly staff meetings. This feedback provided a learning opportunity and helped to improve the delivery of care and support to people.

The agency worked with other partner agencies including health and social care professionals who were involved in people's care. This helped to ensure that people received consistent co-ordinated care.

Good

Is the service well-led?

Our findings

There was a registered manager in place. At the time of our inspection, the registered manager directly responsible for the service was away on a secondment. A deputy and an experienced registered manager who had responsibility for other similar services in the organisation supported us at our inspection.

We received positive feedback about the leadership and there was a high degree of confidence in how the service was run. Care workers we spoke with told us the registered manager was approachable open and honest. A care worker told us, "The manager has an open door policy and if they are unavailable there is always a senior care worker I can speak to." There was a clear management structure in place and care workers had an understanding of their roles and responsibilities. The registered provider told us on the PIR, 'The registered manager is supported by a deputy manager and senior care workers located on site.'

Management knew about their registration requirements with the Care Quality Commission (CQC) and were able to discuss notifications they had submitted. This meant they were meeting conditions of their registration.

Care workers told us the service had a positive open culture. A care worker told us, "It's like a family, but in a good way; everyone helps each other to help people with their care and support." Another told us, "It's a good organisation to work for, so many opportunities." The registered manager told us they have a staff incentive reward scheme. The scheme recognised when care workers had worked well or gone above and beyond what was expected of them with a monetary award scheme voucher. We were told two care workers had to unexpectedly cover a night shift for a similar service and had been put forward for the award in recognition of their commitment to delivering peoples care.

We saw that peoples care was person centred and empowered people to make choices and remain independent in a safe, managed way. Care workers told us they were supported and kept up to date with changes, not just for people but also in best practice and organisational changes. A care worker told us, "We are constantly updated about people's needs, not just verbally and at staff meetings but also documented in daily hand over notes and from new information in people's files."

The registered provider held regular six weekly resident meetings where residents were able to express their views and air any concerns. The registered manager told us that any outcomes from reviews or residents meetings were usually dealt with through inclusion in support plans. The registered provider told us on the PIR, 'We have redeveloped our paperwork used for residents meetings to ensure accessibility for the individuals we support and there is a clear auditable trail between the meetings, support plans and achievement of outcomes.'

The registered provider had a statement of purpose. We saw that this promoted the organisations aims and objectives with an emphasis on promoting people's independence, involvement, choice, rights to be treated with respect and included visions and values of the service. We saw that there was a continuous programme of quality assurance, which upheld those values.

Monthly audits were undertaken followed by a quarterly evaluation of the service. We saw this resulted in action plans being implemented for improvement where targets were not met. We asked care workers if quality assurance helped to drive improvement and they told us "Yes, we discuss feedback form questionnaires and have the opportunity to add our own thoughts," they continued, "We had a problem with some bed rails and as a result of those problems we have improved the whole process which has made it much safer for people."

We looked at minutes of staff and service user meetings. Care workers and people using the service told us and we saw from care plans that the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people.

The registered provider worked with a range of services and health professionals including the local authority, local GP practice, district nurses, CPN's, consultant psychiatrist and speech and language therapist. This helped to ensure a multi-disciplinary agency approach was used to meet peoples care and support needs.

The registered manager told us they attended monthly registered managers meetings with senior managers and organisational managers from other registered services. The registered provider told us on the PIR, 'The registered manager also attends a professional development and action learning network which specifically focusses on the management of adult social care services.' 'Managers and Coordinators are taking part in the 'Joseph Rowntree Housing Trust Leadership and Development Programme' and benefit from bringing all Joseph Rowntree Housing Trust registered managers together, with senior management team, on a monthly basis.' The registered manager told us the programmes enabled them to measure and review the delivery of care, treatment and support against current guidance.