

Northumberland County Council

Northumberland Supported Living Service

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 4 and 12 May 2016 and was announced. We announced the inspection 24 hours prior to calling. This was to ensure that people would be at home on the day that we visited. A previous inspection undertaken in November 2013 found there were no breaches of legal requirements.

Northumberland Supported Living Service is based at Sea Lodge, Cresswell. The service provides personal care and support to two people with severe learning disabilities. The location is rented by the two people from a housing association, who are responsible for the majority of the upkeep and maintenance of the property. Each individual has access to their own bedroom, conservatory/ lounge area, bathroom and garden area. There is a shared kitchen and dining area.

The service had a registered manager who had been registered since July 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had in place a safeguarding policy and staff had received training in relation to the safeguarding of vulnerable adults. They said they would report any concerns to the manager or senior staff. There had been no safeguarding incidents in the service in the previous 12 months. Risk assessments were in place regarding the general operation of the service and also linked to the care delivery for each person living at the home. Regular checks were maintained on the safety of the premises and equipment.

Staffing numbers were maintained at a level that ensured the safety of people who used the service and to deliver individualised care. Proper recruitment procedures and checks were in place to ensure staff employed by the service had the correct skills and experience. Medicines were stored and handled correctly and safely. There were plans in place for the use of "as required" medicines and the use of covert medicines, where necessary.

People were supported to access adequate levels of food and drink. Staff supported people to develop simple cooking skills. People were also supported to visit outside establishments for meals and snacks. Where professionals had given advice or guidance about people's diet we saw that this was being followed.

Systems were in place to ensure staff had regular training and updating of skills and staff confirmed this was the case. Records indicated that the majority of staff had completed all mandatory training. Staff told us, and records confirmed there were regular supervision sessions for all staff members and each staff member had an annual appraisal.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a

law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. Where necessary applications had been made to the Court of Protection to ensure people's interest were protected. Staff were aware of the need for best interests meetings to take place where decisions needed to be made and people did not have capacity to make their own decisions. Where necessary best interests decisions had been undertaken and recorded.

The home had been adapted to promote people's independence with easy access to a range of facilities, with the support of the service provider. The decoration was plain in some areas, but staff said they needed to introduce changes carefully.

We observed staff treated people with great patience and kindness and showed a genuine interest in them as individuals and a real concern for their welfare. Staff understood about people's individual needs and personalities. People's cultural and religious needs were actively supported and encouraged. People had access to health care professionals to help maintain their wellbeing. Specialist advice was sought and acted upon, where necessary. There was evidence in meeting records that staff advocated on behalf of people. Staff understood about treating people with respect and dignity and put this into practice.

People's needs had been fully assessed and individualised care plans and risk assessments developed that addressed all their identified needs. Care records and care plans were reviewed in multiple ways to ensure they met individual's needs and potential changes were identified as soon possible. People had access to highly individual activities based around their likes and dislikes. The registered manager told us there had been no formal complaints in the last year. We saw the service had received several compliments and positive comments about the care.

The registered manager showed us records confirming regular checks and audits were carried out by the service. Staff were positive about the management of the service. They said there was a good staff team who felt well supported by colleagues. They said they enjoyed working in the service and supporting people.

The service had links to a local university and accepted student nurses on training and also providing teaching for the course. Records at the service were complete and contained good detail.

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.

There had been no safeguarding incidents within the last 12 months. Risk assessments related to care delivery and the environment were in place. Accidents and incidents were recorded and monitored.

There were effective levels of staff to meet people's care needs and staff recruit processes were safe and effective.

Medicines were managed efficiently and stored securely. The environment was clean and tidy and maintained to limit potential infection control issues.

Is the service effective?

Good ●

The service was effective.

Staff had access to a range of training and updating and processes to monitor training completion were in place. Regular supervision and appraisals were undertaken.

Staff worked to ensure people had choices and understood the concept of best interests decisions and the provisions of the Mental Capacity Act (2005) were applied.

People were supported to access to a range of meals and drinks and specialist professional advice regarding diet was followed. The home had been adapted to aid access for people and individualised and safe spaces were available to them. People's rooms were personalised.

Is the service caring?

Good ●

The service was caring.

Relatives we spoke with told us they felt staff were exceptionally caring and had a good understanding of people's needs and them as an individual. Relationships between people and staff were good and staff responded to people in a caring and positive manner.

People's religious and cultural needs were supported and relatives told us they were kept well informed of any issues or developments.

People's privacy and dignity was respected and protected. Records showed that staff actively advocated on behalf of people.

Is the service responsive?

Good ●

The service was responsive.

Relatives praised the service and staff highly and said the health and well-being of their family members had improved whilst they were supported by the service.

People had detailed assessments of their needs and comprehensive care plans. Professional advice and guidance was incorporated into plans and actively put into practice. People had core teams that focussed on their care and reviewed all aspects.

Activities were provided that were individual to people's needs and reflected people's particular likes and dislikes. People were supported and encouraged to make choices. There had been no complaints in the last 12 months but the service had received a number of complimentary comments.

Is the service well-led?

Good ●

The service was well led.

A range of checks and audits were undertaken to ensure people's care and the environment the service operated in was effectively monitored. Quality monitoring was also undertaken as part of the wider provider organisation.

Staff said they were happy working in the service and that there was a good staff team there. They said they were supported by the registered manager.

Regular staff meetings took place. The service offered placements to student nurses and provided training to a local university. Records were up to date and contained good detail.

Northumberland Supported Living Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 12 May 2016 and was announced. The provider was given 24 hours' notice because we wanted to ensure there would be someone at location when we visited.

The inspection team consisted of one inspector. This was because the service supports two people and we were aware that the environment was their home. We did not want to distress people living at the home by visiting with a number of colleagues.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local Clinical Commissioning Group. We used their comments to support our planning of the inspection.

People using the service were not always able to speak with us but we observed the interaction between people and the staff who cared for them. We spoke with the registered manager, the operations manager, two senior staff members and two care workers. We also spoke to one relative of a person who used the service and one person's care manager.

We reviewed a range of documents and records including care and medicine management records for both the people who used the service, three records of staff employed by the service, complaints and compliment

records, accidents and incident records, minutes of meetings, communication documents and a range of other quality audits and management records.

Is the service safe?

Our findings

The provider had in place a safeguarding policy and staff had received training in relation to the safeguarding of vulnerable adults. They said they would report any concerns to the manager or senior staff and that any issues would be taken seriously and addressed by the provider. There had been no safeguarding incidents in the service in the previous 12 months. One person had a deputyship agreement in place that provided for the local authority to oversee the managing of their finances. Similar arrangements were being organised for the second person. People's day to day finances were closely monitored, with all expenditure accounted for and regular checks carried out on individual's balances maintained by the service. This meant people were cared for in a safe manner and systems were in place to monitor the safety of people.

We saw that risks associated with individual care and the wider environment were considered. People's care plans contained an analysis of the risks associated with each area of their care and how these risks would be managed. For example, there were risk assessments in place for staff to manage the use of a foot spa that was used to relax the person, and how staff would support the person when they went on trips out. Risk plans highlighted events that may cause distress; such as variation of routine and visiting busy locations and advised staff on action to take to minimise distress and thus risk. People's care files also contained a document to use if a person went missing, with a clear description to give to the police and other important information. Wider risks were also considered, including those associated with the risk of fire and control of substances hazardous to health (COSHH). There was information in people's care records to support them in the event of an emergency evacuation of the home; in the event of a fire.

Checks on the premises and equipment were undertaken. These included regular checks on fire safety equipment such as alarms and extinguishers. Regular checks were also carried out on the home's water system and water temperatures at each outlet around the home. Small electrical items had been subject to a portable appliance test (PAT) to ensure they were safe to use. A fire drill had been undertaken in recent months to ensure that proper evacuation of the premises could be effected. This meant risks at the service, and those associated with people's care were considered and monitored. Action was taken to reduce or limit risk where possible.

Accidents and incidents were recorded on the provider's computerised logging system. The system was used to record trips and falls and any untoward events in the service. We saw that most of the recorded incidents were minor in nature, but where necessary there had been a staff debriefing session, to review the incident, and remedial action taken to limit the possibility of future similar events.

At the time of the inspection there were five staff on duty to support the two people living at the home. The senior member of staff on duty told us that, although the service was not registered to provide nursing care, each shift was covered by a qualified nurse and four care workers. Nights shifts were covered by two care workers, although a nursing staff member from the service or a sister service were on call for advice or support. The senior staff member said each person was always supported by two staff members and occasionally, if a person was going out in the community, a third member of staff would also accompany

them, to drive the vehicle. We witnessed that people seemed well supported and staff were always available. Relatives told us that the staff team at the service contributed greatly to the care. One relative commented, "It's a stable staff team, which I think speak volumes for the service. They are familiar with (name); sense the mood and respond to them." A care manager also told us that the consistent staff team at the service meant they had a good understanding of people's needs.

Staff personal files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, references being taken up, one of which was from the previous employer, and Disclosure and Barring Service (DBS) checks being made. The manager showed us a range of induction programmes used by the service. Full detailed programmes were in place for new permanent staff. However, there were also induction checklists for temporary or short term staff and any contractors who were working at the home, to ensure they understood the systems in place and ensured the safety of themselves and the people lived there. This verified the registered provider had appropriate recruitment and vetting processes in place.

We examined the medicine administration records (MARs) for both people using the service. We found that these records were detailed and well maintained. The MARs contained detailed information about the type of medicine being given and the time it should be administered. There were no gaps in MAR records. MARs were divided into regular medicines and "as required medicines. "As required" medicines are those given only when needed, such as for pain relief. We noted one person's "as required" care plan was not immediately available in the medicine's file. The manager later told us that the care plan had been available, but had been filed in the wrong place in the care record. Because people did not have the full capacity to understand about taking medicines a best interests decision related to this support had been made and documented. One person could be given their medicines covertly, if necessary. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse them. We saw a plan and best interest decision was also in place for this and that it was used only as a final option.

There were protocols in place for the safe storage of medicines, reconciliation of medicines on a regular basis and the receipt and return of medicines from the pharmacy. Medicines were stored in a locked cupboard in the office area of the home. We saw they were stored appropriately, information on when medicines had been received and checked and dates on bottles as to when they were opened. This meant that medicines used in the service were stored and managed safely.

The home was clean and tidy and the manager carried out a cleanliness and infection control audit of the premises. Staff undertook the cleaning of the home as part of their daily tasks. There was access to colour coded mops and buckets, personal protective equipment and colour coded chopping boards in the kitchen, to ensure there was no contamination between raw and cooked foods. Some parts of the home's laundry area required some additional cleaning and vinyl flooring in this area was slightly damaged and required replacement. The manager said this was being arranged. One of the bathrooms was in need of some refurbishment. The senior staff member told us that this person's bathroom was being updated to provide them with a brand new en suite facility. The manager told us there had been a recent external infection control audit at the home. One of the issues highlighted was the need for improved hand wash basins in the staff toilet area and the kitchen. We saw new basins had recently been installed in these areas. This meant appropriate systems were in place for the service to monitor and maintain the cleanliness of the home.

Is the service effective?

Our findings

Staff employed by the service had individual training files. Each staff file contained a list of required training and the date this was last completed. There was also an indication as to when updating training was also required, which varied depending on the training topic. For example, fire training was updated every year, whilst food hygiene training was not due to be renewed for three years. In addition, certificates related to the training were stored in the files and a section sheet served as a further reminder regarding the period between refresher training. The manager showed us copies of staff supervision and appraisal documents. He said that they had recently started to include a list of required training in the appraisal documentation, so it could be reviewed at each appraisal or supervision meeting.

All staff had received Non-Abusive Psychological and Physical Intervention (NAPPI) training to help deal with any behaviour that could be described as challenging. Staff told us this training had been particularly useful and especially the psychological approaches used to help support people's behaviour. Two staff were registered NAPPI trainers who supported other staff and helped review and revise people's care plans, based around the NAPPI approach.

Staff told us they had access to regular training and development. They confirmed that they also had regular supervisions and appraisals sessions. Senior staff received supervision from the manager. Care staff were allocated to be supported by senior staff in the service. Supervision and appraisal documents were detailed and covered a range of areas, including general work related matters, discussions regarding any care issues and personal matters. Staff told us they felt they could raise issues in supervisions, although they also said they could raise any issues outside the formal meeting times.

Relatives told us that communication with the service was good. They told us they received regular email updates from the service and were contacted directly if there were any concerns or changes.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Because people were living in their own rented accommodation they were not subject to DoLS legislation. However, we saw that where necessary applications had been made to the Court of Protection (CoP) regarding matters that may restrict their freedom. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time they need to be made, because they may lack capacity to do so.

Staff understood about supporting people to make choices on a day to day basis. Where more significant decisions were required then a best interests process had been followed, to determine if the action taken was appropriate and the least restrictive option. We saw best interests decisions documentation regarding doors being locked for security at the home, the use of restraining belts when out in the car and the use of medicines. There had also been a best interests decision made over the use of one person's savings to purchase new furniture. This meant appropriate action had been taken by the provider to ensure proper and legal processes were followed in relation to the MCA and CoP.

Because of people's conditions it was not always possible to involve them directly in care decisions. Staff talked about rather than involving people in care decisions, the ethos of the unit was for staff to follow people's leads and respond on a day to day basis around what they wanted to do. Records showed that frequent review meetings took place, both internally with staff team and externally with health and social care professionals. Documentation and comments from relatives indicated that they had been asked to contribute to care considerations, where appropriate.

People were supported to maintain good health through regular access to health professionals, review appointments, doctors' appointments and a range of other health related activities and assessments. We saw from care records that people attended hospital and outpatient appointments. The service was proactive in arranging appointments if there were any health concerns. The staff member in charge told us they had arranged a GP appointment the previous day, but that the person had been unable to attend, so they had rearranged it for the following day. We saw the person was supported by staff to go out in their car and attend the GP surgery, as part of a longer trip out. This meant people's care and welfare was proactively supported.

People's care plans contained information regarding their food and fluid requirements. Where necessary, people had been assessed by speech and language therapists (SALT) regarding specific special dietary needs. One person was required to have a softer diet and we saw a snack conforming to the recommendations of the SALT had been prepared by staff. People's weight was regularly monitored and advice sought where necessary. On the day of the inspection both people went out for their lunch time meal. There were a range of food stuffs available at the home. Staff said they sought advice from relatives about people's favourite foods and meals. They also told us they offered people a range of new foods to try and encourage them to develop new tastes, but also to gauge what foods they preferred.

The manager told us that as part of the lease the provider would carry out some internal work to the home. The home was well adapted for the needs of the people living there. People had their individual spaces, but could also socialise together if they wished. Because people's behaviours could sometimes be described as challenging the environment was designed to be safer, with heavier furniture and limited free objects that could be picked up. Both people had access to outside spaces that were easily accessible. One person had a bathroom with a whirlpool bath and mood lighting to aid relaxation. The overall decoration of the home was in need of updating in some areas. Decoration was plain which meant that certain areas, such as the dining area were less homely. Staff and the manager told us that they had tried to introduce some additional furnishing and embellishments to the home; however it was sometimes difficult as people did not always react well to changes. They said that they were looking to improve the ambience but this needed to be undertaken slowly. A care manager told us that changes to the environment could sometimes distress people and need to be undertaken subtly.

Is the service caring?

Our findings

Relatives we spoke with told us they were very happy with the care their relations received from the service. Comments included, "I am delighted. The care is of the highest standard" and "We look on the staff as part of the extended family. The atmosphere of the place is good. Certainly feel they are more settled."

We spent time observing how people and staff interacted. When people were at home there were always two members of staff available to help and support them. Staff were always available and always aware of where people were, without being overly intrusive of their personal space. They ensured that the environment was safe for them and intervened appropriately if they began to become distressed or unsettled.

There was a good relationship between people and staff. Staff always talked in a calming manner and had a good knowledge of people's particular likes or disliked and an understanding of what certain behaviours indicated. They encouraged people to undertake tasks for themselves and were patient in their approach. We saw that people responded positively to the approach of the staff and appeared comfortable with them.

Staff told us that much of the support they offered to people was through following their lead. They understood that they were working in people's home and that, as far as possible, people should be able to make decisions about what they did. They told us that certain behaviours or gesture indicated what people wanted to do and that they would respond to these. For example, whilst we were on the inspection one person repeatedly walked to the garden gate, where their mobility car was parked. Staff told us that this behaviour indicated that the person wanted to go out in the car. They immediately made arrangements and took the person out over the lunchtime period. They said they would be guided by the person and were able to describe the types of behaviours and gestures that indicated the person wanted to return home. This meant that people were involved in their care and able to indicate to staff what they wanted to do, and staff supported this. The manager described how one person's religious background and family beliefs were supported.

Records showed that people had accessed advocacy services in the past. Staff said that advocates had been involved in representing people's views in meetings. They told us that people were also supported by their care managers and family members. Records showed that care managers and relatives had been involved in discussions regarding best interest decisions and assessments regarding CoP decisions. Records also showed that staff accompanied people to meetings and appointments to support them.

People's privacy and dignity were respected. During the inspection staff ensured that people had privacy. For example, when we arrived at the home one person had decided that they wished to return to bed after breakfast. Staff asked us not to disturb the person and made sure that we did not intrude whilst were looking around other parts of the home. We saw in documents that staff were looking to purchase self-adhesive frosting for one person's bedroom windows, which looked out on to a nearby road, so they had more privacy when they were spending time in their room. The layout of the home meant that people had access to individual spaces, including their own lounge/conservatory areas and bathroom. This meant they

could choose to spend time privately on their own or interact with the other person who lived there.

Staff explained how people were supported and encouraged to be as independent as possible. They told us how they had developed programmes to improve people's independence by implementing step by step programmes. For example, one person was being encouraged to learn how to make their own hot drink. Staff explained how they were making small changes, so the person was learning to switch the kettle on and then pour the hot water into the cup. They told us that the next step was to extend this so the person learnt how much coffee to put in the cup. People's care plans also contained information regarding supporting their independence, such as how they should be encouraged to get ready when going swimming and when washing and dressing. Photographs in one person's care file showed that they had visited a bank to withdraw their own funds for an activity. A care manager told us they felt people were supported to be independent and develop skills. This meant people were encouraged and supported by staff to learn and develop skills that helped maintain their independence.

Is the service responsive?

Our findings

People had wide ranging and comprehensive care plans. Plans included information about people's daily routines as well more detailed plans related to their particular care needs. There were also detailed instructions for staff to follow if people became distressed and presented with behaviours that could be described as challenging. Care plans identified behaviours and gestures that had been recognized as having certain meaning for each individual. For example, what behaviours indicated a person was becoming upset or what gestures or behaviours indicated a person was being caring. Plans also indicated that people required support from two staff at all time and three staff if they were going out in the community.

Detailed care plans covered activities such as supporting bathing and personal hygiene, nutrition, appropriate dress, supporting mobility and ensuring effective skin care. There were risk assessments associated with care plans which detailed issues that may arise and how staff should respond to limit the risks. For example, one person had a rigid daily routine and became distressed if this was not followed. To limit risk staff were required to follow the routine and ensure there were regular meal times. Other risk assessments were linked to the use a foot spa, used to provide relaxations and the use of a softer diet for meals.

Care plans contained detailed information for staff to follow and reflected the advice of professionals. For example, for one person, following an assessment by a speech and language therapist (SALT), guidance had been given that food should be cut up into small pieces and softer type foods offered if the person became distressed. We saw this advice was incorporated into the person's plan and carried out in practice, as a snack had been prepared for the person and cut into small pieces. Care plans also indicated they responded to people's personal preferences. For example, one person now had a bath in the evening as this fitted better with their routine, rather than in the morning when they had just woken up.

Care plans also contained step by step guidance for staff to follow to help support people. For example, for one person there were detailed instruction for them to follow if they presented with behaviour that could be challenging, the various actions they should take to distract the person and calm them down and the observations they should make. Staff showed us that they had facilities to observe a person, whilst not being in the room. Care plans were reviewed at regular intervals.

Staff told us that each person was supported by a core team of staff. They said the core team met regularly to review people's care, look at what had gone well recently and also plan future developments. Each core team member also had a specific task within the group. For example, staff had responsibilities for organising birthdays and Christmas celebrations, ensuring care files were up to date, ensuring people's photographs of activities were kept up to date, for them to look at and ensuring there was good contact with relatives. Staff were also tasked with "opportunity planning", which involved looking for ways to enhance people's care or develop their skills in the future. This meant care plans and care delivery reflected people's needs, incorporated professional advice and guidance and was regularly reviewed and updated.

Activities were based around people's individual needs, likes and dislikes. Both people had access to their

own Motability vehicles and went out into the community on a regular basis. One person enjoyed going out purchasing a daily newspaper and also visiting stations to watch the trains. There were numerous photographs showing the person enjoying this activity. People were encouraged to participate in the daily running of the service, making meals, drinks and similar activities. There was also a range of equipment for them to use and easy access to an open garden area. Staff explained how people enjoyed gardening activities during the summer and also barbeques. Both individuals had access to their own television and one person had recently purchased a wall projector that could be used to project relaxing images on a wall in the lounge area. A care manager told us she found that people were frequently out visiting the local community.

Staff were aware that it was important that people maintained good contact with their families. People went to visit family members, including for meals. One person's family had recently purchased them a tablet (hand held) computer. Through the home's Wi-Fi system their person was able to access Skype, a video communication system, and see and speak to family members who were not always able to visit. The tablet computer meant the person was also able to move around the home, whilst in contact with their family members, to show them things. Staff and relatives told us that for one person staff had driven them to meet relatives, who lived away, at a half way point. The relative told us, "It wasn't perfect obviously, but I really appreciated the effort the staff made." This meant there were a range of individual activities for people to participate in and staff ensured there was good contact with extended family member, to limit social isolation.

The provider had a complaints policy in place. There had been no formal complaints made about the service in the last 12 months. Staff talked about how they knew people they supported well and were able to tell, by their gesture and behaviours if they were happy or upset. There were several emails and letters from relatives expressing great satisfaction with the provision of care by the service. This meant that whilst there had been no formal complaints regarding the service, staff were attuned to people's individual expressions of happiness or concern throughout the day. A relative told us they had not made any complaints and had nothing they wished to raise. One relative commented, "I've no complaints. I can't think of anything that would improve it. There really isn't anything."

Both people using the service had information documents in their files that could be sent with them if they needed to attend hospital in an emergency. The documents contained information about their particular health care needs and how they may express themselves. This meant there was information available to ensure staff at the hospital were able to respond appropriately in such circumstances.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since July 2011. The registered manager was on leave during the first day of our inspection but was present on the second day we visited the service.

Staff told us that they felt well supported by the manager and senior staff of the service and could raise any issues. Comments included, "I've a good relationship with (registered manager). He is supportive" and "(Manager) is a good manager. He's been very supportive." Regular staff meetings took place involving both qualified nursing staff and care staff. The manager told us that the staff team had also recently taken part in a programme, run through the provider's HR department, looking at improving staff relationships and developing communications system. An action plan had been developed as part of this process and this action plan formed part of the discussion agenda at team meetings.

Staff told us they were happy working in the service and enjoyed caring for people. Comments from staff included, "I like my job. I like the scope; always looking to develop" and "There is a lot of gratification in the job. It's nice when (person) shows they are happy; lots of laughing and smiling." Staff also told us there was good team working in the service and staff pulled together. Comments on this included, "We all pretty much all get on. The staff team tend to work together. When we need to we work together and forget any differences"; "There are good staff. We get on reasonably well as a team" and "There are all different personalities. We all have our different strengths and weaknesses, but we gel."

The manager and senior staff told us about links with one of the local universities. They told us that third year student nurses spent placements at the service. The manager felt this was useful as they brought fresh thinking and new ideas to the service. They also appropriately questioned practice as part of their learning process. Following the taking of student nurses at the service staff had also spent time providing training sessions for the university on the NAPPI behavioural management system. The manager told us that staff from the service had also visited other similar locations to provide support and advice.

The manager and operations manager carried out a range of audits and checks on the service and the delivery of care. Regular audits were undertaken on medicine administration at the service, checks that first aid boxes were up to date, care plans, staff files and a range of other areas. Weekly checks were also undertaken on people's individual Motability vehicles to ensure they were safe to use. Accidents and incidents were reviewed and, where necessary, remedial action taken. Following any incidents a staff debriefing session was undertaken to review the circumstances, check that staff were alright and consider changes to future approaches. Additionally, there were wider corporate quality meetings where managers from a range of the provider's services considered how each service area compared to CQC quality standards. Additionally, an operations manager visited the service at least annually and conducted a wider range review of care and documentation.

Records for the service were well kept and up to date. Daily records contained good information regarding events in each person's daily life and any issues or concerns. There was also a communications book that

staff used to ensure that important information was passed between shifts. A senior member of staff told us that they were looking to move to electronic rather than paper records. They said they had initially piloted a process and then had only recently commenced moving to a fully electronic record system. They showed us how a range of documents were maintained, including daily records and care, along with other continuous records, such as weight monitoring. Care staff told us that they felt the move to electronic records was alright, although sometimes found it difficult to get in the office to complete records and felt it could take them away from supporting people at time.