Care and Support Sunderland Limited

Care and Support Sunderland

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on the 5, 6, 7 and 10 August 2015 and was announced. This meant the provider knew we would be visiting. This was the first inspection of Care and Support Sunderland.

Care and Support Sunderland provides personal care for adults who have a learning disability in several separate supported living services. They are all close to local amenities such as shops and community centres. At the time of the inspection there were nine supported living services. Some people lived on their own, in other services six people lived together.

At the time of the inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 organisation was introducing a new training strategy which changed refresher timeframes for training. Some of the houses we visited had very organised training records and we could see that training was in date; in one house however we were unable to assess whether training was up to date as systems were quite disorganised. Training needs analyses were in place which identified required training and a new training strategy was being implemented.

Staff said they felt well trained and well supported. We saw that the staff had regular supervisions but not all staff had recorded evidence of an annual appraisal.

Some of the care records we viewed included mental capacity assessments which had assessed that people lacked the capacity to make decisions around care and treatment. They also had reviews which stated that consideration should be given to applying for community DoLS. We asked staff in other houses about deprivation of liberty safeguards (DoLS) and mental capacity and they explained that assessments were required and that social workers had been reminded but we saw no evidence of this. One operations manager said, "Customers at [house] do not require DoLs due to any restrictions with the home presently." This was in relation to the house where reviews stated consideration should be given to applying for DoLS.

Not all care records had been kept up to date. We found the support being provided to one person was in line with new guidelines from specialist healthcare professionals but their care records did not reflect their current needs. In another house care plans were dated 2012; they had been reviewed on a regular basis and temporary changes to care had been recorded on implementation sheets but the care plan itself had not been re-written which meant people may not have received the appropriate level of care to meet their current needs.

In other houses care records were up to date; detailed and contained specific information about the person's preferences and routines. People and their relatives were involved in care planning and in one house the people living there had written their own care plans with the support of staff.

People and their relatives told us they were safe living at Care and Support Sunderland services. Staff were knowledgeable about protecting people from harm and a recent campaign had been launched to encourage staff to speak up about concerns; this gave a direct line of contact with the chief executive officer.

Bed side guides had been introduced which included a range of information needed by staff who were supporting people with mobility needs; this included an occupational therapist assessment and a record that information and moving and handling strategies had been cascaded to all staff.

Care and support plans had integral risk assessments which identified control measures for managing and reducing risk. Emergency contingency plans were in place in relation to specific risks such as epilepsy and behaviour which might challenge the service as well personal emergency evacuation plans.

There were mixed messages about staffing levels. Some staff explained that they had moved services several times which they had found unsettling, but they did say that when they raised this with the manager they hadn't been moved again. Some relatives had also commented that there had been lots of changes over the past year. Others said there were enough staff.

Staff were recruited in a robust way which had recently included a panel of relatives; induction was well organised and included the care certificate; two weeks of training and in-house induction.

Medicines were managed safely although some care plans were more individualised than others.

Care plans in relation to managing behaviour which may challenge were detailed and well evaluated.

Referrals had been made to specialist health care professionals for people who had specific needs in relation to epilepsy management; behaviour management and dietary needs.

Summary of findings

Relatives felt their family members were well cared for. One relative said, “One thing that gives the greatest comfort is knowing they are well cared for.” People also told us they liked living where they did.

Relatives said they knew how to complain and we saw there were procedures in place for staff to follow should any concerns or complaints be raised.

There was an open culture and several lines of communication in place to ensure people, their relatives and staff were kept up to date with changes happening across the organisation. Staff were positive that the changes were improving the quality of the service provided and motivation remained high. One relative said, “If there is something they always consult us.”

There were a range of audits in place to monitor and assess the service, some of which were repetitive and time consuming but there was work being completed to streamline the quality assurance process to ensure it was fit for purpose.

Summary of findings

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. Staff understood about safeguarding and how to raise any concerns.

Risks were assessed and managed and contingency plans were included in some risk assessments.

Staff recruitment was managed well and family members had been involved in some recent staff interviews.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective. Staff training records had not been kept up to date so it was difficult to assess whether they had up to date training and knowledge.

Staff said they were well supported and supervisions were in place but not all staff had evidence that they had received an annual appraisal.

Some people had been assessed as lacking capacity and staff said they had requested the local authority apply to the court of protection to authorise deprivation of liberty safeguards but we saw no evidence of this.

Is the service caring?

Requires improvement

The service was not always caring. We observed staff did not always engage proactively with people whilst offering support with meals. Staff were respectful of people and involved them in decisions around the running of the household as well as in relation to their care and support.

People's independence was encouraged and staff understood that people had a right to make their own decisions.

Is the service responsive?

Requires improvement

The service was not always responsive. There were inconsistencies in the quality and timeliness of care records. Some were very individualised and detailed and others had not been updated and therefore did not meet the person's needs.

Some people had full activities timetables whilst other people chose how to spend their time on a day to day basis.

Is the service well-led?

Good

The service was not always responsive. There were inconsistencies in the quality and timeliness of care records. Some were very individualised and detailed and others had not been updated and therefore did not meet the person's needs.

Summary of findings

Some people had full activities timetables whilst other people chose how to spend their time on a day to day basis.	

Care and Support Sunderland

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 5, 6, 7 and 10 August 2015 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service incorporating supported living services for adults with learning difficulties and we needed to be sure that someone would be in.

The inspection team was made up of one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we visited the registered office and three of the nine supported living services. We met fourteen people who were using the service and spoke with one visitor. We also contacted five relatives by telephone. During the course of the inspection we spoke with five senior members of staff including the registered manager, two operations managers, the nominated individual and one service manager. We also spoke with seven front line staff including service co-ordinators, residential officers, senior care staff and support workers. We contacted the local authority safeguarding team and commissioners of the service to gain their views.

We looked at nine peoples care records and viewed medicine records and health care files. We looked at safeguarding and complaints logs, recruitment files, training, supervision and appraisal as well as records relating to the management of the service.

Due to people's support needs not everyone we met were able to directly answer questions about the care they received so we spent time with people in the communal areas.

Good

Is the service safe?

Our findings

One person told us, "I'm happy living here, I feel safe." One relative said, "I don't doubt the staff one bit, I know my [relative] is very safe there, I wouldn't leave them otherwise."

We saw that a 'Stand up, speak up' campaign had recently been launched to encourage staff to share concerns. Each house we visited had information on the campaign, some had posters on display and there were information cards available for staff. One staff member said, "The speak up policy encourages you to be open and honest in the team and to raise concerns that aren't necessarily safeguarding's. You can also email the chief executive and get a response." One manager said, "Safeguarding is a standing agenda item on team meetings. I like the information that's being put out as staff might be concerned about whistle blowing so it makes it easier to raise concerns. Staff are proactive and come if there are any issues."

An operations manager explained that at induction they try to make it an everyday thing to share any concerns about anything, including safeguarding. They said, "We have an open door policy and want staff to feel comfortable to share and raise things."

Another operations manager explained that they had worked with the health and safety executive and occupational therapists to develop a 'bed-side guide' for moving and handling guidance. The guide included information on hoist and sling use; an occupational therapist assessment and cascade of information form, support plan and risk assessment including pictorial information, and monthly checks lists. They said, "We have an external trainer for moving and handling training and occupational therapists come in and demonstrate on particular equipment."

Support plan documents had integral risk assessments which detailed specific control measures for managing and reducing risks related to moving and handling and medicines. Individual emergency contingency plans were also in place for specific risks to people such as behaviour that may challenge services; management of epilepsy and missing people.

People had personal emergency evacuation plans in place and staff had allocated responsibility for health and safety and fire checks which some people helped with. One staff member said, "We check the alarms, extinguishers, and things and do a full unannounced evacuation."

We asked about accident and incident recording. A service coordinator said, "If it's part of someone's usual behaviour then we wouldn't do an accident or incident form unless there was an injury. So for epilepsy we complete the seizure monitoring form and use that for analysis but not an incident form." They added, "If it was a serious injury we'd do a form and notify CQC as well."

Care and Support Sunderland provide support across nine houses and had in place a staff structure which showed the number of commissioned hours and the number of staff hours provided. The structure included service managers; service coordinators, residential officers and support workers all of whom were overseen by operational managers. We viewed rotas which showed the commissioned hours were being met and that flexibility was taken into account in relation to ensuring people had support to attend activities if they wished to do so. Where there was an assessed need waking night staff were provided as well as a member of staff who 'slept in'.

One staff member said, "I've been moved around a bit to cover maternity and sickness, but it got a bit too much so I had a word and I've been here ever since, it's good." Another said, "I moved here from another home, I've been here about six months, it's a lovely home, there's good banter here, the staff are good." One relative said, "There aren't enough staff, people don't go to activities." They went on to say, "Some staff are good, you can't take that away from them." Another relative said, "I definitely think there is enough staff, I have no concerns." Another said, "I don't like the way the carers keep changing, you feel like you just get to know one set and then they move. I feel like there have been lots of changes in the past year." All staff we spoke with acknowledged there had been lots of changes across the organisation and in relation to workforce transformation but they were positive that changes were happening in order to improve services for people.

The recruitment process included completion of a disclosure and barring service check, previously known as criminal records bureau (CRB) checks, and the receipt of two references. There were links with Sunderland college

Good

Is the service safe?

who completed functional assessments on applicant's numeracy and literacy skills so if support was needed this could be assessed and provided for people if they were successful at obtaining employment.

An operations manager said, "We use internal recruitment if there's a promotion opportunity. The chief executive interviews everyone and service managers have been interviewed by a panel of family members. There was joint agreement on who was appointable. They also felt the quality of staff internally was very good."

Medicine support plans were in place and had been evaluated regularly but some were more personalised than others. For example, we saw plans with information on the cup people liked to use to take their medicines, where to place the medicines for people until they were ready to take them. Authorisations for homely remedies for mild pain relief or the relief of a sore throat were in place and had been signed by the person's doctor but had not been reviewed since January 2013.

Each person's medicine information included the reason for the medicine and any known side effects. If people had been prescribed 'as and when required' medicines there were protocols in place which had been signed by the prescribing doctor.

We observed medicine administration in one house and saw that care plans were followed appropriately and the staff recorded the administration of medicine on a medicine administration record (MAR). The staff member explained how they checked the medicine before giving it to the person and that they only recorded that it had been administered after they knew the person had taken it. For any 'as and when required' medicine they explained that they recorded the time it had been taken and added any notes to the back of the MAR chart. They also said, "We also do stock checks of medicines, particularly 'as and when required medicines' after we've given them out as they aren't used daily so we make sure everything's right."

Requires improvement

Is the service effective?

Our findings

One relative said, “The staff are very good. They are caring about what they do, which I think is important.” Another said, “The staff do a brilliant job, they know what they are doing.”

An operations manager said, “The care certificate has been introduced, and the last three induction programmes have introduced the care certificate.” The care certificate is used to ensure new staff working in social care have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

We saw that induction included a two week training programme as well as specific in-house inductions, E-Learning and completion of the Care Certificate. One staff member said, “I'm showing them [a new staff member] what to do and how, it refreshes me as well so it’s good to go through things and answer questions.”

A service manager said, “A training needs analysis has been completed; the procedure for training is being changed, but all the training staff need has been requested now.” We saw that requests for training included safeguarding, dignity, information governance, medicines, mental capacity, epilepsy, dementia care, autism, ethical care, control and restraint and moving and handling. One staff member said, “I’ve done moving and handling, first aid, DoLs, epilepsy, autism, safeguarding, and medicines. You are reassessed in each home you work in for medicines and I did a safe handling of medicines workbook which is marked and you get a certificate if you’re competent.”

Some staff teams had very organised training records and we were able to see that training was up to date; in other teams it was disorganised and the records we did see showed that some training was out of date. A senior staff member said, “We are in the process of rolling out an updated training programme, all the refresher time-frames are changing but staff are booked to complete it all.”

We spoke to the operations manager who said, “The training programme is outstanding. We have a partnership with Sunderland college who work with us to design and develop diplomas for staff. We have a social responsibility to the whole of health and social care to ensure staff are well trained.” They added, “The company Sunderland people first deliver half a day training. They talk about Winterbourne and give the perspective of someone who has a learning disability. It has a real impact on staff.”

One staff member said, “I get monthly supervision.” We saw that other staff had had regular supervisions but not all staff files showed evidence of annual appraisals. Staff did tell us they felt well supported and had had an annual appraisal. A service manager said, “We aim to have six supervisions a year including an appraisal, but we can do more if it’s needed.” One service co-ordinator said, “We do supervisions every other month for all staff. Annual appraisals are all done and in place, I’ve had all the necessary training.”

Some steps to ensure compliance with the supreme court judgement made in 2014 that extended the scope of Deprivation of Liberty Safeguards (DoLS) had been made. These safeguards are part of the Mental Capacity Act 2005 and are a legal process that is followed to ensure people are looked after in a way that does not inappropriately restrict their freedom. If a person is receiving care in a supported living environment, arranged by the local authority, the Court of Protection must authorise any deprivation of liberty. This is the only route available.

Staff from one house said, “DoLS would have been done when we de-registered.” We saw people had mental capacity act assessments which had been completed; one persons in May 2014 and another’s in July 2014 by the service manager and social worker. This assessed people as being unable to consent to care and support and had not been reviewed. Local authority reviews had been completed for each person in March 2015 which stated that consideration should be given to applying for a community DoLS. There was no evidence that this had been completed. We spoke with the operations manager about this who said, “We are in a process with the social worker currently to review requirements. The customers at [house] do not require a DoLS due to any restrictions within the home presently and we are awaiting update from social workers to review all customers in the near future.” People living at this house had been assessed as lacking the capacity to consent to care and support. This shows a lack of understanding of the mental capacity act code of conduct and how it relates to supported living services.

Care records for a person who lived alone and had 24 hour support stated they were unable to give consent in writing

but could make their wishes known verbally and non-verbally. It was recorded how staff should seek consent by only asking one thing at a time; allowing time for the person to process information and if they refused twice to offer an alternative option. Refusals were to be recorded. The service coordinator said, "There's no community DoLS in place but is earmarked to apply for one." They added, "It's about protecting people. Making sure people are cared for and not deprived unless it's necessary and an assessment's in place to say they don't have the capacity and capability to understand."

In a different house the service co-ordinator said, "[Person] had a community DoLS in their previous placement and an assessment is required here, the social workers' been reminded about it and they are aware."

It is recommended that formal records of requesting the local authority to assess whether people are being deprived of their liberty are maintained, as lack of evidence requesting assessment may constitute a breach of the mental capacity act code of conduct; particularly where people have been assessed as lacking capacity but have no recorded best interest decisions.

There were detailed plans in place to support people who may present with behaviour which challenges services. Plans described the person's history, the behaviour, what it meant, what the potential triggers where and how to respond to the behaviour. For example to involve the person and to be consistent with the approach. It was recorded in the evaluation notes that the consistent approach of staff was working well and having a positive impact on the person.

Should behaviour escalate there were emergency contingencies in place which included protocols for the administration of as and when required medicine as well as behavioural approaches and debriefs for staff. Care plans stated the numbers of staff that needed to support the person at home and when in the community and whether the staff should be male or female.

Nutrition scoring sheets were used to identify people who were at high risk in relation to nutrition and who needed specialist input from speech and language therapy (SALT) or dietitians. Detailed information was available from SALT teams including specific dietary requirements that staff were following. The background to the involvement of the SALT team was recorded and in one person's records we could easily follow a chronology of events which resulted in changes to the person's diet. There were lists of high risk food in peoples care records as well as indicators that a person was experiencing swallowing difficulties. Eating and drinking support plans and risk assessments were in place for people who needed support in this area.

One person said, "I had chicken and mayonnaise for lunch it was nice, the staff made it for me." We asked about menus and staff explained that they did have a menu but more often than not they asked people what they wanted to eat and made that. We saw that people were involved in shopping and cooking, with one person making their own breakfast when we arrived for a visit.

People had separate health files which included records of their weight and current medicines. People had been referred to specialist services in relation to speech and language therapy; epilepsy and neurology and people living with dementia. There was also a calendar of appointments and records relating to other professionals involved such as the doctor, practice nurse, chiropody, audiology, district nurse and so on.

We saw people had separate epilepsy files. We viewed one person's which contained several recording forms for seizure monitoring but there was no support plan or risk assessment in relation to epilepsy management. We asked one of the staff and the manager about this. The manager said, "We don't need all those different recording forms, we only need to use one." We asked about the care plan and risk assessment and were told, "It'll be in the care records file." We did find the care plan and noted that it gave a clear description of the person's seizures and how it should be managed. The manager said, "All the information needs to be kept together for easy reference doesn't it."

Epilepsy assessments included a detailed description of the seizure and any risks, including SUDEP, sudden unexpected death in epilepsy. One person used an epilepsy monitor and set it independently with staff. The plan described why the monitor was used and how to use it as well as the action staff should take if the monitor went off. There was an analysis of a recent reduction in seizure activity which linked a possible change in diet and poor physical health which may have impacted on the retention of anti-convulsion medicines in the persons system. A specific plan was in place for the administration of rescue medicines which had been developed by the specialist epilepsy nurse and signed by the whole staff team.

Requires improvement

Is the service caring?

Our findings

One relative said, “One of the things that gives the greatest comfort to a parent is knowing they are well cared for.” Another said, “My [relative] is very well cared for. She is doing very well; it’s praise to the home.” Further comments from relatives included, “Oh yes, I think she is more than well cared for,” and, “They help her keep her independence, she is very happy, I can tell.”

One person said, “It’s nice here, I like it.” A staff member said, “It’s good working here, I love the guys, I like to get them out and about, bowling, darts, playing pool.”

We observed lunchtime in one house and saw one person was helped to the table and was supported on a one to one basis with their meal which had been pureed. We observed the staff member supporting and noted there was limited communication and engagement. The staff member did not explain what the person was having for lunch they just put the food on a spoon and took it to the person’s mouth, there was no explanation offered to the person until a second staff member starting speaking to the person.

We observed one person who had sensory needs in relation to their sight was supported in a proactive and sensitive manner. They enjoyed sitting at the dining room table which they were supported to do and staff understood that this meant they wanted to join in and do some paperwork so they brought paper and pens for the person. At lunch time staff asked what the person wanted and said everyone else was having fish fingers, the person said, “Oh yes.” The meal was brought to them cut into small pieces as detailed on their care plan for eating and drinking. Staff explained where the plate was and asked if the person wanted a drink which they went to fetch, returning with it and saying, “Here’s a drink of juice at your right hand.” The person asked where and was supported hand on hand to the cup, as soon as the person held the cup staff let go and the person was able to support themselves independently. A second member of staff approached and asked, “Would you like a pinny [apron] on to keep yourself clean.” The person said, “No” and this was respected.

We visited another house and observed that people were relaxed in their home and wandered around freely spending time in the lounge or their rooms as they chose to do so. Staff spent time chatting with people whilst they watched television or had a cuppa and the atmosphere was relaxed and homely. Staff initiated conversation and encouraged everyone present to join in, involving them in the conversation.

People freely chatted about places they had visited with staff and plans for the future, such as visiting family and friends, going to the park. The atmosphere was very sociable and people were clearly enjoying each other’s company having a laugh and a joke. When some people returned with the weekly shop others got up and helped put items away, carrying cleaning products out to the garage whilst someone else asked if people wanted a cuppa. After all the shopping had been put away everyone sat together in the lounge and relaxed with the music on whilst they had a drink and chatted about how they would spend the evening and what they wanted for tea.

In another house we visited we saw that people directed their care and had written their own care plans. One person had a one year plan and a three year plan that they had developed with staff in order to support them to identify priorities in relation to the things they wanted to achieve.

One person had been involved in identifying an increase in their support needs in order to support them to attend job interviews as they were seeking employment. The person told us, “I need some help as I’ve never done it before.”

Advocacy services were on display in some of the houses we visited and staff told us services were available to people if they needed it.

Requires improvement

Is the service responsive?

Our findings

One person said, “I like the staff, I like going shopping in the car, it’s the best way.” Another person said, “I'm going home tomorrow to my Dad’s. We went out last night and I had ice-cream, it was yellow, I liked it.” There were mixed views from relatives, one said, “Sometimes they could do with some more activities, like jigsaws or games. But then I think of the age range and I'm not sure they would want too.” Another relative said, “She goes out a lot, goes shopping, bowling and to the disco. She always seems well occupied.”

We found there were inconsistencies across homes in the quality of care records and the systems used for recording information. Some contained detail on the person’s preferences and areas of independence and specific detail on how the person liked to be supported whilst a minority were very functional and stated what the person needed support with but not how they liked to be supported. This was fed back at the time of the inspection and the service manager and operations manager said they would be addressed.

We found information relating to one person’s support with eating and drinking was kept in several different files. In the persons ‘bed side guide’ a risk assessment in relation to moving and handling recorded the position the person needed to be in order to eat and drink safely and that they should remain in that position for a set period of time before being moved. This was due to risk of aspiration. This had been assessed on 2 July 2014. We asked a staff member about the link between mobility and aspiration risk and they said, “It’ll be in the care records.”

In a different file we saw an eating and drinking support plan dated 15 July 2014 which had been signed by staff up to and including 6 March 2015. This did not mention that the person needed to be in a specific position and not moved after eating for a set time period. Implementation notes had been completed on 7 August 2014 which stated, ‘SALT visited today. [Person] can have a snack or drink whilst in bed but must be in the upright position, [person] must remain upright for 40 – 60 minutes before lying back down. This will aid digestion and reduce risk of aspiration. These instructions had also been recorded on to a professional support record document but again we saw no evidence that this instruction had been transferred to the care plan.

A mealtime risk reduction plan completed by SALT and dated 13 October 2014 was in place which detailed specific information about posture and timeframes before moving. We saw no evidence that an updated care plan had been put in place following the receipt of this plan. There were no staff signatures on this document. At the time of the inspection we observed that the person was being supported in line with the SALT guidelines but there remained concern that if staff followed the care plan it would lead to increased risk and possible aspiration as the persons needs would not be met.

We spoke to the manager about this who said, “I will make sure a new care plan and risk assessment is in place straight away.” We also raised this as a concern with an operations manager and the registered manager.

We spoke to the staff about the systems used and access to the information and they were not able to explain a comprehensive system of information storage.

In one house we saw that care plans had been written several years ago, for example a mobility support plan had been written in 2012 but had been evaluated regularly. One staff member said, “We are getting a new format for care plans so we’ve been told to hold off renewing them until the new plans are in place.” We asked a service manager about this who said, “If there’s a transient change the care plan stays the same and we record it on the implementation plan but if it’s a permanent change the support plan is updated.” We did see that implementation sheets were used to record any temporary changes to the person’s needs.

All other care plans we viewed had been written within the last year and had been evaluated on a regular basis. Evaluations contained detail of why the care plan was still in place, for example, ‘still requires the full support of one member of staff to shower’.

In another house we saw that care plans had been written in December 2014 and had been fully evaluated in May 2015. Some people had documents called ‘A quick guide to me’ which detailed important routines to follow and any communication support the person needed. The detail was such that it included which products the person liked to use and very personalised detail in how to support in a sensitive way so as not to disrupt their individual preferences and routines.

Requires improvement

Is the service responsive?

People had 'Essential information about me' booklets in their care records which included contact details for family members and their health care professionals, any medical conditions, how the person communicated and their general likes and dislikes.

Communication plans detailed how to communicate with the person; what certain gestures and facial expressions meant; and that staff should not offer too many instructions or choices as it distressed the person.

We visited two people who told us they had been involved in directing their care and writing their support plans, taking the lead with this and ensuring they were in control as much as possible. Their care records included lots of personalised information in relation to what was important to the person, what worked well for them, what they didn't like, what activities they wanted to do, what they wanted to change and the support they needed. Information also included the skills they wanted their staff to have in relation to supporting them, such as communication and mindfulness. Mindfulness is defined as a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations, used as a therapeutic technique.

We looked at staffing rota's and saw that staff were brought in on the days of set activities in order to support people to attend. Staff explained to us that sometimes people chose not to go to the activity or they did something different.

Some people had an activities care plan which showed a structured timetable which was reviewed on a six monthly basis.

One relative told us, "The staff always involve us in everything, planning what she needs and things." Another said, "Any problems and we are always consulted, we work together and talk through everything." We saw there was a system in place for the completion of monthly reviews but these had not always been completed routinely. The reviews included information on people's health, activities, family contact, goals and hopes and feedback from family members.

Relatives were asked about their understanding of the complaints process. One relative said, "I know I could speak to anyone if I had any concerns." Another said, "If I had any concerns I could speak to [the manageress]."

There was a pictorial complaints policy in place as well as a complaints log and record for recording any action taken and the outcome in response to complaints. One home we visited had information on an anonymous complaint which had been fully investigated by an operations manager within set timeframes.

One senior staff member said, "We are establishing good relationships with family members, working to build trust and open discussions which we have on a regular basis." They added, "I believe families are happy, there's certainly been no complaints. I plan to put year books together for people so they can look through achievements and celebrations with family and staff. It can be used as a prompt for memories and communication." They went on to say, "I spoke to family members about the care plans and we agreed the way forward."

Good

Is the service well-led?

Our findings

One relative said, "I could talk to the manager about anything, they are very good." Another said, "Manageress is really approachable; I think she is very good." One staff member said, "I'm well supported, we have team meetings and service user meetings as well."

A service coordinator said, "[Operations manager] is a dream, they are lovely but they do expect you to do your job properly. I've learnt loads from them." They went on to say "The chief executive is really approachable and easy to get on with, you can ask for things and you normally get them. Senior managers are very supportive; they explain things no bother at all."

Regular newsletters were completed. We saw the April/May edition included information on whistleblowing and the launch of 'Tell Philip' cards. These cards had been introduced as a direct link to the Chief Operating Officer to people could raise any concerns with him. There was a guarantee on the card that any concerns would be looked into. Each newsletter also included information on competitions people could enter and who had won previous competitions with photographs and write ups. There was information on 'team of the month' and 'colleague of the month' to acknowledge achievement as well as information on training, improvements to services and a section celebrating success.

Business meetings were held monthly with senior managers and chaired by the chief operating officer. These included discussions around workforce transformation, recruitment, training, organisational restructure and quality. Information from these meetings was cascaded to front line staff through their individual team meetings.

Staff meetings happened regularly and agenda items included whistleblowing, recording, workforce transformation, team work and a review of people's needs.

A variety of other meetings were held including health and safety groups; CQC and quality standards; and a senior management team meeting happened on a weekly basis.

One manager said, "There are regular CQC and quality meetings. I would notify CQC of any deaths, or serious injuries, safeguarding's, investigations, hospitalisations. I'd check on the website if I wasn't sure what to do." A service co-ordinator said, "It's my responsibility to manage and notify of deaths, safeguarding's, concerns about managers or staff, any relevant accidents such as broken bones and injuries, hazards to health."

Handovers were completed at shift change and were written and verbal. We saw there was a handover document used as well as the communication book and a diary.

Monthly management reports were being completed and included a report on supervision and appraisals; safeguarding alerts; an overview of audits completed in-house, a variety of meetings; health and safety; accident and incident reporting and training. We saw that information from these reports was used within management supervisions to discuss any analysis of information including actions that needed to be completed.

Monthly home audits of compliance were completed and included compliments and complaints; fire safety; health and safety' moving and handling; medicine management; care and support documentation and suitability of record keeping. This audit then produced an action plan which included a review of actions from the last audit; actions required and who would complete them and a report on any outstanding actions.

In another home monthly audit had been completed which included actions to complete supervisions and appraisals. A monthly medicine audit was completed which included a summary of actions completed from the previous audit. Monthly health and safety and infection control audits were completed on a routine basis with no actions identified.

In house service manager audits were also completed for medicines; finances; health and safety and infection control.

An operations manager explained that a working group had been set up to review all policies and procedures. They explained they were working on policies being made more user friendly and removing the jargon from them. We saw that one of the service managers we spoke with was part of this working group. A service manager told us they were on a working group for looking at the effectiveness of the current system of audits and quality assurance to develop best practice in terms of processes and procedures and to reduce the level of duplication.

Good

Is the service well-led?

One of the operations managers said, “We are very well supported by [chief executive officer] they are forward thinking. We have weekly meetings to keep us up to date with policies and procedures. They lead from the front. Very passionate about making sure we have the right services for people. They really want to raise standards.” They added, “They encourage customers to have a real say and to be included. There are gardening competitions where people win money to spend on improvements in their services. Customers also designed Christmas cards and birthday cards. All staff get a birthday card which was designed by customers.”

Another operations manager said, “There’s an organisation wide survey. A friends and family meeting with the chief operating officer. Commissioners also do independent surveys to look at value for money and things.” Staff confirmed that surveys were completed on a regular basis and one had recently been completed for friends and relatives but the results had not been made public at the time of the inspection. A colleague’s survey had been published in 2014 which reported on the overall satisfaction of staff working within Care and Support Sunderland but also reported on specifics in relation to training, support and supervision and team working. There was also a section titled ‘You said…. We listened’ which detailed areas that would be reviewed in response to feedback. Examples included the launch of a new whistleblowing policy which had been completed; improving the amount and quality of training that would be provided and publishing a training prospectus. We saw that a workforce development strategy was in place. Staff told us that they felt their views were listened to and that the organisation was developing and improving.