Manchester City Council - Adult Directorate

Short Term Intervention Service

Inspection report

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15 May 2017

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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 10, 12 and 15 May 2017 and the first day was announced. The other days were spent contacting people and staff to gain their views on the service. This was the first inspection of the service since they were registered with the Care Quality Commission in April 2016.

The Short Term Intervention Service is one of a range of services offered by Manchester Council. The service aims to support adults with a learning disability in gaining confidence and skills to manage practical daily tasks, to enable them to live as independently as possible. Short term intervention is a short term service which may be provided for up to twelve weeks, although some people received a service in excess of this timescale. As well as promoting independence, the service also provides a period of assessment to identify any other services people may require in the longer term.

The Short Term Intervention Service provides a range of services to people in their own homes, including personal care. This is a short term service aimed at maximising people's independence for the time they receive support. At the time of our inspection 16 people were receiving a service and there were two new referrals into the service.

There was a registered manager at the service. 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.

People who used the service told us they felt safe with the staff and the care they were provided with. Staff had a good understanding of possible indicators of abuse and told us action they would take should they become aware of any concerns. Appropriate recruitment procedures were in place although the service had not needed to recruit new staff for some time.

Risk assessments were formulated around aspects of support in the home, for example when administering medicines, moving and handling and communication. We also saw a detailed risk assessment in place for managing an individual's behaviour within a community setting. The service carried out a hazard risk assessment, based on risks presented by the person's home environment.

There were procedures for staff to follow should an emergency arise outside of normal working hours. The service had out of hours arrangements and staff were instructed to contact the reablement out of hour's management team.

Medicines administration refresher training was overdue for three employees. The registered manager produced evidence to show that this training had been arranged and all three staff were attending refresher training during dates in mid May 2017.

The training matrix indicated that staff covered aspects of training relevant to the support worker role, for example in safeguarding, medicines administration, infection control, health and safety, food hygiene, personal safety plus a practical element of training in moving and handling.

There were policies and procedures in place in relation to the Mental Capacity Act 2005. Staff had received training on the Mental Capacity Act (2005), and staff were able to describe how they supported people in a way which followed the principles of this legislation.

We found people were cared for, or supported by, appropriately trained staff. People told us that the majority of staff were caring and staff always stayed the agreed length of time.

People were supported to regain and maintain their independence wherever possible. Staff were able to describe how they supported and encouraged people to complete tasks as much as they could for themselves. Staff recognised that reskilling people was the whole purpose of the service and provided help and support accordingly.

People were treated with dignity and respect whilst receiving care. Staff respected the people they supported and maintained their privacy whilst providing personal care. The service had recently supported someone with a terminal condition. The individual had planned their own funeral with the help of staff and other health professionals. This highlighted that staff were caring, compassionate and went the extra mile when supporting someone at the end of their life.

Support plans identified the care and support people needed to ensure their safety. We looked at a sample of electronic support plans. These mapped out what was expected of workers at each visit and included support guidance in relation to personal care, nutrition, finances, health and community activities.

We saw references to culture and faith within support plans, observation checks on staff and in risk assessments. The service acknowledged and respected an individual's faith and cultural beliefs.

Some people were supported to access social activities within the community. The registered manager told us it was important to find out what activities and events people were interested in and then gauge if people were able to access these. Supporting people in the community gave staff the opportunity to assess people's social skills and build on these wherever possible.

The registered manager received support from team leaders within the staff team, other reablement colleagues and their line manager. The registered manager understood their responsibility to inform the Care Quality Commission of specific events that occurred in the service.

Staff we spoke with told us they received supervisions in the form of job consultations. Staff meetings took place on a regular basis and were well attended by staff. The welfare of staff was important to the service and staff spoke highly of the support available to them.

Staff from the short term intervention service worked alongside any new providers for a period of time. The service worked in partnership with other organisations for the benefit of people using the service.

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.

Risk assessments specific to individuals were completed. Staff had access to clear and specific guidance as to how they should manage people's risks.

Staff were administering medicines on occasions which were appropriately documented on a medicines administration record (MAR) template.

There were mechanisms in place to promote people's safety. People were supported by sufficient numbers of staff who were aware of safeguarding practice and when to report any concerns.

Is the service effective?

Good

The service was effective.

Staff training equipped staff with the knowledge and skills to meet people's needs. Staff felt well trained and competent.

Staff understood the principles of the MCA and acted in people's best interests when necessary.

People were encouraged to follow healthier diets.

We found that people were receiving appropriate support with their healthcare needs.

Is the service caring?

Good

The service was caring.

Support plans had been developed with the person and any representatives and were about the individual.

The service offered gender specific care and support where possible. Staff considered the service would benefit from more

male support workers.

The service promoted privacy, dignity and independence well.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they began to use the service.

The service was flexible to people's needs. Requested changes to support were accommodated when possible.

The service acknowledged and respected an individual's faith and cultural beliefs and communicated these to staff.

Is the service well-led?

Good

The service was well led.

There were systems in place for monitoring the quality and safety of the service. Checks were carried out to monitor and observe staff practice in a person's home

The service worked in partnership with other organisations for the benefit of people using the service.

Staff told us they felt supported in their role.

Feedback was not formally gathered from people but people considered they were asked about the service provided.

Short Term Intervention 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 the 10, 12 and 15 May 2017. The first day of inspection was announced as we wanted to make sure that the registered manager would be in the office on the day of the site visit. The other two days involved speaking to people using the service and staff supporting them over the telephone. The inspection team consisted of one inspector.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any incidents which put people at risk of harm. We refer to these as notifications. A notification is information about important events which the service is required to send us by law.

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 the information in the PIR, any notifications that the provider had sent us and any other information we had about the service. We used this information to help us plan the inspection.

We contacted commissioners of care and Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We visited the provider's office where we spoke with the registered manager. We later spoke with two team leaders by telephone and three support staff. We spent some time looking at documents and electronic records relating to people's care and support and the management of the service. We sampled records from training plans, staff meetings and quality assurance records to see how the provider assessed and monitored the quality and safety of the service.

At the time of this inspection there were 16 people receiving care and support from the short term intervention service and two new clients recently referred into the service. As part of the inspection we spoke with seven people who were receiving support.

Good

Is the service safe?

Our findings

All the people we spoke with using the service said that they felt safe when their support workers were in their home or accompanying them in the community. We asked care workers if they had received training in relation to safeguarding adults and if they know what to do if they had any concerns. All the care workers we asked confirmed they had completed training, understood what safeguarding meant and knew how to report any issues. One care worker said "Our job is to keep people safe. I've done the training and would report any concerns to my manager."

They went on to tell us signs they would look for in an individual that might indicate abuse was happening, for example bruising, having no money or acting out of character. Staff recognised that people they supported were vulnerable, particularly to possible financial abuse and were aware to raise any concerns around capacity and finances with managers. We saw evidence of this during our inspection. People in the service were advised not to open the door to strangers and always ask any callers for identification. A member of staff we spoke with told us of a password in use for one individual. This was only known to the staff providing support and it was a phrase that the individual recognized. The routine was that staff would knock on the door and then whisper the password to the individual behind the door. This meant that care workers were able to identify themselves before the person opened their front door. We were assured that mechanisms were in place within the service that promoted people's safety.

Short term intervention is an interim service for people with a learning disability to help engage people and maximise their independence. The service was expected to be provided for a period of up to 12 weeks, however we saw that the service continued to provide support for individuals for more than 12 weeks in some cases. When the service identified that it was not appropriate or safe to remove or transfer support for individuals to another agency, it continued to provide a service on these occasions.

We gathered information about how the service managed risks to people. Before receiving support from the service, assessments were carried out to determine if they were able to meet the persons care needs safely. This ensured that the service only provided support to people whose needs they were able to meet.

We saw examples of risk that had been identified at assessment and were noted within care plans that were specific to individuals. Prior to providing support the service carried out an environmental risk assessment when undertaking the initial assessment, known as a hazard identification assessment. This assessment covered common risks posed by the person's home environment; for example any obstructions in the home, carpets and flooring likely to be a slip or trip hazard and animals in the home.

We saw risk assessments were formulated around aspects of support in the home, for example when administering medicines, moving and handling and communication. We also saw a detailed risk assessment in place for managing an individual's behaviour within a community setting. The risk assessment provided support staff with a background history of the person, known triggers and identified preventative measures staff could take whilst supporting the person out in the community. We saw that staff had signed the risk assessment to confirm they had read and understood the content. The band of risk prior to the assessment

being completed had been rated red and scored 16. This was reduced to a risk rating of orange and a score of 9, given the information for staff providing support contained within the risk assessment. We were assured that the risks posed to the individual in a community setting would be reduced and their safety maintained.

Care workers would sometimes support people with their medicines but only with those that had been prescribed to the person by their GP. The provider had a medication policy in place and staff confirmed they had read and understood the policy. We saw that the policy and good practice guide incorporated professional guidance from the Royal Pharmaceutical Society and the Care Quality Commission. The policy and its appendices aimed to provide guidance so that reablement support workers could support customers safely with their medication, whilst promoting their independence and maintaining their dignity and privacy.

We looked at one person's medication administration record (MAR) which confirmed people were receiving medicines as prescribed by their GP. The MAR chart contained the time and date of administration and was signed by the staff member giving the medicines. The MAR chart also included space to record the number of any medicines received in the month, with staff recording the total daily dose and keeping a daily balance. This was good practice and meant staff were aware of reducing stock and could order medicines in a timely manner if this was ever required. Staff we spoke with told us they would contact the office for further advice if someone persistently refused to take medication.

We saw systems in place to record accidents and incidents. These were electronically stored on the MiCARE system, an electronic database used by the council for social care records. At the time of our inspection there had been no recorded accidents or incidents but the registered manager told us anything reported would be investigated to identify any actions required to reduce the risk of the incident or accident occurring again. For example, following an accident it might be identified that a person's support needs had changed and therefore corresponding changes would be made to their care and support plan.

There were sufficient staff to keep people safe although the registered manager recognised that the service was limited in growth due to the low number of staff employed. People who used the service said their visit times suited their needs on the whole and staff stayed the agreed length of time. Rotas we saw confirmed this. One person we spoke with told us their support worker rang them if they were running late. This meant that people were kept informed about their care. At the time of our inspection the registered manager was planning to recruit more staff and the reablement service as a whole was meeting to formalise a new induction process.

We reviewed the processes in place for staff recruitment. The short term intervention service was a local authority service and the turnover of staff was low. Current staff had been redeployed from other departments within the local authority. We saw that these people had been employed in similar caring roles, for example within children's services or home care, and had transferrable skills.

All recruitment was managed and handled centrally and new staff, when appointed, were subject to the council's recruitment and selection criteria. Staff had been checked with the Disclosure and Barring Service (DBS) on initial employment. DBS checks are used to identify whether staff have any convictions or cautions which may prevent them from working with vulnerable people. As in line with council policy the compliance team renewed staff's Disclosure and Barring Service (DBS) clearance every three years to ensure that staff were still appropriately employed to work within the service. We were confident that the recruitment procedure meant that people using the service were kept safe from those unsuitable to work with vulnerable adults.

There were procedures for staff to follow should an emergency arise outside of normal working hours. The service had out of hours arrangements and staff were instructed to contact the reablement out of hour's management team. The policy outlined for staff examples of incidents that should be reported, for example not being able to gain access to a person's home, any changes to a person's needs or if they were unwell.

Good

Is the service effective?

Our findings

People we spoke with said staff knew how to care for them and had the right skills and abilities to do their jobs. People we spoke with told us, "Yes, they're alright," "We're happy with the help" and "[Staff member] has never let me down."

At the time of our inspection there was no formal induction process in place as there had been no need for one in the past. Staff working for the service had been previously employed in similar caring and support roles for the council and had been redeployed into the new service. Turnover of staff was low and recruitment of external staff had not been necessary. The registered manager and other reablement managers had recognised that this was likely to be needed in the very near future as long serving staff were looking to retire. Registered managers of all the reablement services, including the short term intervention service, had arranged a meeting for Monday 15 May 2017 to formalise an induction process based on the elements of the Care Certificate. We will check on progress of this at our next inspection.

The provider told us that staff had received both corporate and other training specific to the role of support worker. We asked for and were sent a copy of the training matrix. This identified training that staff had completed, was due or was overdue. We saw that three members of staff had not completed medicines administration refresher and this was now overdue from March and April 2017.

The registered manager produced evidence to show that this training had been arranged and all three staff were attending refresher training during dates in mid May 2017. Other staff were also scheduled to attend at different intervals during May, June and July. This meant that by the end of July all support staff would have received refresher medicines administration training and would be more effective in the support role.

The training matrix indicated that staff covered aspects of training relevant to the support worker role, for example in safeguarding, medicines administration, infection control, health and safety, food hygiene, personal safety plus a practical element of training in moving and handling.

Staff we spoke with confirmed they had access to e-learning modules and some were completing National Vocational Qualifications (NVQ's). The service had a small room on site containing five computers which staff could access to look at company policies and undertake e-learning training. This was evidenced at the time of inspection. One staff member told us, "I am encouraged to ask for training." When asked staff told us training was mainly face to face with some online e-learning. Another member of staff had recently completed day one of a two day behavioural management course. They had specifically requested this training as they were currently supporting an individual who was known to display challenging behaviour in certain situations. They told us they had found the first day of training provided by the NHS 'really useful'. This meant that staff were competent and confident when providing support to people using the service.

During the inspection we spoke with members of staff to assess how staff were supported to fulfil their roles and responsibilities. Staff we spoke with said they had supervisions, referred to as job consultations, and records we saw confirmed this. Supervisions provide an opportunity for management to meet with staff,

feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. We saw examples of completed job consultations undertaken with staff. The member of staff discussed any client issues identified and updated the line manager with progress around support packages. Personal development, management support and staff issues were also agenda items discussed during supervisions.

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Staff had received training on the MCA and Deprivation of Liberty Safeguards via an on line e-learning package. Staff we spoke with were able to outline the circumstances they needed to be aware of if people's mental capacity to make certain decisions about their care changed. Staff did not carry out capacity assessments directly however, we saw that they were involved and had input in the process. They were recognised as having a good relationship with the person having the capacity assessment, knew the background to the case and were able to act as interpreter in the example we saw.

Once it was deemed that a person did not have the capacity to understand the information relevant to the decision, for example around managing their finances, then a best interest decision was taken and again we saw that the service was represented and involved in reaching the decision made in the best interests of the individual. In a recent best interest meeting it had been suggested by a representative of the service that a referral be made to the local authority's client financial services to take on appointeeship for the individual. The service recognised that the individual would be protected from financial exploitation and abuse and that bills would be paid on time. Others agreed and this was decided to be in the person's best interests. This demonstrated to us that staff understood the principles of the MCA and acted in people's best interests when necessary.

Staff were only responsible for providing support with dietary requirements to a small number of people as most either did not require this level of support or had family members who helped. Staff we spoke with were able to give us good examples of when their intervention and support had helped people adopt a healthier lifestyle, which had improved their general well being.

We looked at the support people received with their healthcare needs. We found that either the individual's themselves or their family members were usually responsible for arranging routine healthcare appointments. However staff told us that when this wasn't possible, for example if there were no other family members involved, then care workers referred people to relevant healthcare professionals to seek advice, if they recognised someone was unwell or had concerns about a change in a person's needs. They gave us particular examples where people had required more input than others and had been supported to see their GP, consultant, podiatrist or optician. People were receiving appropriate support with their healthcare needs.

Good

Is the service caring?

Our findings

People and their relatives were happy with the care they received and told us that staff were caring. One person described the staff who supported them as, "They're great. I'm happy that they help me."

Staff we spoke with told us they enjoyed supporting people and getting to know the people they supported, especially as the service was time limited. Staff told us, "It's all about the person you're supporting. It fits in with what they want", "We all go over and above. We do what's needed for people" and "I enjoy helping people. Getting them on the right track."

We saw that support plans had been developed with the person and any representatives following an initial assessment and were about the person. Support plans and risk assessments provided staff with a background history of the person being supported, especially if they were already known to services. There was a personal statement about the individual, including information about their family history and how they preferred their support to be delivered. Staff we spoke with were able to describe some people's likes and dislikes and knew their behaviours. This meant that people receiving care and support were more likely to receive care that met their preferences.

People told us that for most of the time they got support from consistent staff. People were able to state the gender of carer who supported them and the times they wished to receive their calls. We noted that over two thirds of clients receiving a service were men. However, the service only employed one male care worker. Staff we spoke with confirmed that this was not currently an issue, however agreed that the service could do better and employ more males. One person we spoke with told us they preferred support in the morning but that support was delivered in the afternoon. They went on to tell us this wasn't a problem and said, "I have to wait for them. I don't mind."

People were treated with dignity and respect whilst receiving care. Staff we spoke with told us they supported people with their dignity and one staff commented, "We work with people to respect their privacy and dignity. I treat people how I'd want to be treated." Another told us that when offering support with personal care, for example assisting a person to shower, "I ask if I'm needed, if they're decent and then knock on the door. I know doors are probably open but I still knock and wait for a response." This showed us staff respected people they supported and maintained their privacy whilst providing personal care.

People were supported to regain and maintain their independence wherever possible. We saw that people's care plans had reference to encouraging people to maintain their independence. Staff were able to describe how they supported and encouraged people complete care tasks as much as they could for themselves. Staff recognised that reskilling people was the whole purpose of the service and provided help and support accordingly.

People we spoke with were positive when asked if the service promoted their independence. Staff were passionate about their role in enabling people to become as independent as possible in the limited time they accessed the service. One staff member summed up the service and said, "We go in and assess. With

our help they are able to do things." They went on to explain how people were supported to microwave their own ready meals with the use of a coloured sticker system. Corresponding coloured stickers were placed on meals and then onto the microwave dial so that people were able to do this independently. One person we spoke with using the service confirmed that staff had shown him how to microwave a meal but now could do this on his own. This highlighted to us the caring attitude of staff wanting to promote independence and encourage people.

We were told how the service had recently supported someone with a terminal condition. The individual had felt excluded during hospital consultations and considered that they had not been provided with enough information about their condition. Staff became involved and accompanied the person to hospital appointments. They researched local networking groups and supported the individual to attend sessions. The client produced a bucket list which staff helped them to achieve wherever possible, including a short break away and shopping for a wig. The individual planned their own funeral with the help of staff and other health professionals. This highlighted that staff were caring, compassionate and went the extra mile when supporting someone at the end of their life.

As part of our inspection we visited the offices of the Short Term Intervention Service. We found that electronic and paper documents were stored securely and the appropriate checks were in place to ensure that confidentiality was maintained for the people using the service.

Good

Is the service responsive?

Our findings

Records showed people had their needs assessed before they began using the service with an integrated assessment. This ensured the service was able to meet the needs of people they were planning to provide a service to. The information was then used to complete a care and support plan which provided staff with the information to deliver appropriate care.

People told us they were supported by sufficient staff and that there was continuity of care. Not all of the people we spoke with who used the service said their visit times suited their needs but staff were on time and always stayed the agreed length of time. If calls were sometimes late, one person told us they were notified of this by a call from the care worker.

Support plans identified the care and support people needed to ensure their safety. We looked at a sample of electronic support plans. These mapped out what was expected of workers at each visit and included support guidance in relation to personal care, nutrition, finances, health and community activities. Staff considered that support plans and guidance provided them with the information to carry out the support role.

We saw references to culture and faith in support plans, in observation checks on staff and in risk assessments. One risk assessment noted that a person followed a culturally specific diet and ate only halal food. This informed staff for when they supported the person eating out in the community. Another family had requested that staff removed their shoes before entering the house. The manager had explained that providing support with no shoes on may not be safe for the individual, but had suggested that staff would place blue protectors over their shoes and the family agreed to this. This indicated to us that the service acknowledged and respected an individual's faith and cultural beliefs.

Reviews of support plans and packages of care occurred after six weeks. There was also the option to adjust the support plan based on the review. People were asked how the support was going and if anything needed to be changed. Staff we spoke with told us changes could be made more regularly and said, "We are always assessing [a support package.] If it's not working for the person then we can change it." Staff told us support did change as people gained confidence and became more independent.

Staff told us that the times of support could be altered, for example if an individual was going somewhere or had an appointment. One staff member said, "We agree times [of support] with the client but we can be flexible if they want it earlier or later. As long as they appreciate I've got other clients." We spoke with a person who told us their support times were different if they had a GP appointment or was being supported to the post office.

Some people were supported to access social activities within the community. The registered manager told us it was important to find out what activities and events people were interested in and then gauge if people were able to access these. Supporting people in the community gave staff the opportunity to assess people's social skills and build on these wherever possible. One person had been quite isolated prior to

receiving a service. They now attended a yoga session, sing-a-long session and chair exercises all held locally and their social needs were being met.

Due to the nature of people's disability the service tried to source appropriate activities and then it was sometimes necessary to introduce people to these slowly. It was identified at assessment that one person liked to play with balls but preferred quieter environments. A support worker told us that a squash court was hired which meant that support was delivered in a controlled way, it was a quieter environment and the individual was able to pursue an activity they enjoyed. We were confident that people had their social needs met if they expressed a wish to do this.

People told us they knew how to raise any concerns or complaints they may have about the service. Most people we spoke with told us if they had any concerns they would speak to their care workers and felt they would be listened to. People were given a copy of the complaints procedure when they first started to use the service which detailed who to contact if needed.

We looked at the complaints policy and records of complaints. We saw there was a system in place to make sure any concerns or complaints were recorded together with the action taken to resolve them and the outcome.

We contacted several professionals for feedback about the service and received positive comments including the following from a health professional, "The short term intervention team have gone above and beyond to ensure [person] has been supported and has enabled time to allow better planning of their longer term support needs. I am very aware that the team have been very accommodating and flexible. This in itself is highly commendable and truly person centred."

Good

Is the service well-led?

Our findings

People we spoke with were happy with the care and support they received and how the service was managed. Prior to the inspection CQC sent questionnaires to people receiving a service and received three replies. The results of the responses were displayed within the PIR. Two out of the three people knew who to contact in the care agency if they needed to. Two people also thought the information received from the service was clear and easy to understand, whilst the third person did not know. Due to the nature of the service we could not be sure if the people who had responded were still receiving a service. People we spoke with at the time of the inspection told us they would speak to their support worker if they had a problem.

The registered manager received support from team leaders within the staff team, other reablement colleagues and their line manager. The registered manager understood their responsibility to inform the Care Quality Commission of specific events that occurred in the service.

We looked at systems the service had to monitor the quality and safety of the service. Registered managers from all reablement services met monthly to discuss quality of services, ways to improve and any patterns or trends. Care co-ordinators collected paperwork from people's houses and audited MAR charts, finance sheets and any entries made around the provision of support.

We saw that checks were carried out to monitor and observe staff practice in a person's home and were provided with examples of completed observation checks. Staff were observed during all stages of the support visit, including on arrival and whilst providing support. Staff were assessed with regards to their awareness of infection control, adherence to policy and procedure, promoting of independence and communication with the individual. Staff told us these checks kept them 'on their toes' and made them think. Staff we consulted during the inspection found them beneficial.

Staff administering medicines as part of a support package were assessed as competent to do so. The competency assessment checked staff abilities to dispense, administer and record medicines but also checked their understanding in relation to applying creams, administering ear, nose and eye drops and also administrating medication that was inhaled.

The registered manager acknowledged that supervisions of staff had not been done as regularly as they should have been. We saw there were five supervisions from March and April that were overdue. Staff we spoke with however felt fully supported by care co-ordinators and the registered manager and had no qualms asking for advice or assistance on a daily basis if this was necessary. One support worker told us, "I'm happy. I know I can ring up the office and request a job consultation. They'd get me in next week." This meant that staff felt well supported in their role.

Staff said the registered manager was approachable and always had time for them. They said they felt listened to and could contribute ideas or raise concerns if they had any. Staff told us they had team meetings where they were encouraged to put forward their opinions and felt they were valued team members. One staff member told us, "Staff meetings are definitely useful. It's good to see colleagues, catch

up, share information and bring any concerns."

Minutes from meetings were documented and distributed to all staff. We asked for examples of these and were sent minutes from team meetings held in September 2016 and February 2017. A staff meeting had been scheduled for the day of our inspection but this was postponed until the following week. Staff were kept up to date about council and corporate issues. We saw that in the meeting held in September 2016 staff had been briefed about the pending integration of health and social care and the new models of care. This meant that staff were kept informed by management about issues that might affect the service.

We saw no evidence of formal feedback gathered from people whilst using the service and the registered manager told us this was something they were planning on introducing. They felt it would be more beneficial to have someone independent from the service collect and collate feedback, as this would mean people were more likely to give both positive and negative feedback. We will check on progress of this at our next inspection.

We did see however, people's responses from the questionnaire distributed by CQC prior to the inspection. Two from three respondents agreed that the care agency had asked what they thought about the services provided. This showed us that support workers and team leaders were asking people's opinions about the service but this was not being recorded formally.

The registered manager provided examples of referrals to other services. Referrals could be made into a company who specialised in finding paid employment for people with a learning disability, or a preferred college course. Following assessment of people's homes they could be signposted to the fire service for 'Safe and Well Checks.' People were assisted with housing bids, tenancies and benefit claims. There were links established with advocacy services and the service kept a register of chiropodists, opticians and dentists. Once people were identified as ready to move on but required more long term care a provider was identified. Staff from the short term intervention service then worked alongside the new provider for a period of time. This helped the person feel more at ease with the new provider and gave staff the opportunity to share information, for example about how the individual preferred care and support. This demonstrated the service worked in partnership with other organisations for the benefit of people using the service.