PSS (UK)

PSS Seel Street

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

PSS (Person Shaped Support) Seel Street is a social enterprise formed in 1919. The service is located in Liverpool City Centre and is registered to provide personal care through three different services; Shared Lives, Supported Living also known as 'Making Homes' and Community Support.
Not everyone using PSS Seel Street receives regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Shared Lives is a form of support where vulnerable adults and young people over 16 years old live at home with a specially recruited and trained carer. It provides flexible day care, short breaks, intermediate care or long term placements in a carer's home. At the time of the inspection, the service provided the regulated activity to 38 people.

The Supported Living service provides care and support services to enable people who need additional help to live independently in their own home. This service provides care and support to people living in five 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of the inspection, the service provided the regulated activity to nine people.

Community Support provides support for people with learning, physical and mental health difficulties to live independently in the local community. At the time of the inspection, the service provided the regulated activity to three people.

Both the Shared Lives and Community Support scheme had their own registered manager. The Supported Living scheme had a manager in post who was not yet registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the overall rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Safe recruitment procedures were in place to ensure that staff and Shared Lives carers appointed were suitable to work with vulnerable people. There were appropriate numbers of staff deployed to meet people's needs and to ensure people received consistent and timely support. Staff had received training in safeguarding and an organisational policy and flowchart procedure was in place to guide them. Carers

understood how to recognise abuse and how to report concerns or allegations.

Medication was safely managed and administered by staff who had received the relevant training. Clear guidance was in place for those that required 'PRN' (as required medication). The registered provider had strengthened their systems and processes around medication recording following 'themed reviews' and lessons learned as a result of safeguarding enquiries. Regular medication audits and staff observation records were completed to ensure safe administration.

Risks to people's health, safety and welfare were assessed and detailed information was available to guide staff to support people to stay safe, whilst promoting their independence and autonomy. Accidents and incidents were well documented and analysed for future learning and prevention. Arrangements were in place to ensure people lived in a safe environment and regular health and safety checks were completed in the supported living and shared lives settings.

Support plans were tailored to the individual and reflected each person's needs and preferences and provided detailed guidance how they liked their routine to be followed. The registered provider had developed innovative means of enabling people's support requirements to be documented in video format. This creative technology was used as a tool for people to tell their own story in their own words.

People, relatives and Shared Lives carers spoke positively about the service and the staff team who supported them. People described the staff as 'brilliant'. People felt involved in making decisions about their care. One person told us, "I'm asked where I want to go and what I want to do. Staff talk to me; I'm not ignored or left out."

Staff were assisted in their role through induction, training, supervisions and an annual appraisal. Staff and shared lives carers told us they felt well supported and sufficiently trained in order to carry out their roles effectively. Some staff had received tailored training to meet people's specialist needs such as epilepsy and specific equipment training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service operated within the principles of the Mental Capacity Act 2005 (MCA) and processes were in place to assess people's capacity.

Staff worked with external professionals to support and maintain people's health and well-being. People were supported to access health appointments and there was evidence of health action plans and health passports within files.

People had access to a complaints procedure and complaints were dealt with appropriately and in accordance with the timescales set out in the registered provider's policy. People felt confident that any concerns would be listened to and acted upon.

Staff understood the vision of the service and maintained a focus throughout their practice on the delivery of support in a person centred way. People told us that staff promoted their independence and encouraged their daily living skills.

The culture of the organisation was one of continuous improvement and development and the registered provider demonstrated their commitment to this through proposed new initiatives such as the implementation of the 'outcome star' tool to measure progress against people's individual goals.

Roles and responsibilities were clearly defined with a designated manager for each service and a Head of Service to provide oversight. There were a number of different systems in place to assess and monitor the quality of the service, ensuring that people were receiving safe, compassionate and effective care. Audit systems were robust and consisted of a variety of self-assessment tools to examine performance in key areas. This included quality assurance checks in respect of areas such as care plans, health and safety and medication.

The vast majority of feedback we received was positive and people were complimentary about the running and organisation of the service. One person told us, "It's the best it's ever been."

The service worked with wider partners to ensure people received safe, effective and compassionate care. The registered manager told us how they engaged with local partners from community policing to deliver training to people on safety in the local community.

The registered provider had notified the CQC of events and incidents that occurred at the service in accordance with our statutory requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

PSS Seel Street

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 24 and 25 April 2018. We gave the registered provider 24 hours' notice of our inspection. This is because the service delivers personal care to people living in a supported living and shared lives setting and we wanted to be sure the registered managers and people who used the service would be available to answer our questions during the inspection.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we contacted social care professionals who have involvement with the service to ask for their views. We were not made aware of any concerns about the care and support people received. 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 any improvements they plan to make. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. We used all of this information to plan how the inspection should be conducted.

As part of the inspection we visited the office and met with the Nominated Individual for the organisation, the Director of Services, the Head of Services for community support and Head of Quality and Compliance. We spoke with the three managers for each scheme and five members of care staff. We spoke with 12 people who used the service both on the telephone and at the registered office. We also spoke with five relatives and nine Shared Lives carers on the telephone. We looked at 10 care plans for people who used the service, including three from each scheme and a video support plan. We reviewed three staff personnel files, four carer recruitment files, staff training and development records as well as information about the management and governance of the service.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving a service from PSS. Comments included, "Oh yes 100% feel safe here" and "I have no accidents and I'm looked after well."

Risk assessments were in place to assess and monitor people's health and safety whilst ensuring their autonomy and freedom was respected. For example, one person was noted to be vulnerable in the local community. Measures were in place to promote access to the community in a safe way. This included the provision of a mobile phone which the carers were reminded to charge regularly. Guidance was available to staff on control measures to mitigate any identified risk to the individual. For example, staff identified that a person was vulnerable to financial abuse as they did not have capacity to manage their own finances. Records showed that staff checked the person's money at each shift and monthly checks were completed by a team leader to ensure expenditure was monitored and any anomalies could be identified.

A log was maintained of all accident and incidents which occurred at the service with a focus on future learning and prevention. Staff completed accident and incident forms and each document was then reviewed by a manager to encourage reflection to ensure any remedial action was taken to prevent re-occurrence, such as the review of risk assessments. The Head of Quality and Compliance provided further oversight and compiled quarterly reports to allow any trends or recurrent patterns to be identified.

Medication was managed safely and administered by staff who were trained and who had been assessed as competent. People told us they were happy with how their medication was administered. One relative told us, "[Relative's] medication is done regularly and on time, that is important, [relative] needs medication with food. Staff are very careful about that."

In response to previously identified medication errors, the registered provider undertook a 'themed medication review' which identified how their systems and quality assurance processes could be further improved and we saw that actions identified had been completed. For example, an action was for all shared lives placements to have medication checks completed as part of their ongoing monitoring and we saw these audits were now in place. The manager of the supported living scheme also explained how they had implemented changes following learned lessons from previous medication errors relating to poor handover procedures. This included the implementation of a new handover document to ensure medication quantity checks were completed at each shift by two staff.

Protocols were in place to guide staff in the safe use of 'PRN' (as required) medication. The head of quality and compliance told us about the organisation's commitment to the STOMP (stopping over-medication of people with a learning disability) pledge. We saw that a record was held of all occasions when PRN medication was administered, with the reason for administration and outcome clearly documented.

Recruitment processes remained safe because pre-employments checks had been completed on prospective staff before they were appointed. A robust procedure was in place to evaluate the suitability of Shared Lives carers before vulnerable adults were placed with them. This consisted of a thorough

assessment process with a focus on the applicant's skills, experience and understanding before approval from an independent review panel.

The training matrix showed staff had received training in safeguarding. Staff understood local reporting procedures and a policy and procedure flow chart was in place to support them.

People told us they received care and support when they required it and there was a sufficient amount of staff to provide this. People had continuity of care and enjoyed consistency of a regular staff team. Comments included, "Staff are on time and come when they should. I choose which staff I have. I have done some interviews for staff" and "Staff are up to scratch, they know me well and are continuous. If there is anything wrong, like someone is poorly, they send someone else."

People living in supported living services had PEEPs (personalised emergency evacuation plans) and fire evacuation plans were discussed for those in Shared Lives placements. Regular health and safety checks were in place to ensure people lived in a safe environment and staff supported people to raise any repairs with their individual tenancy. Staff received training in infection control and risk assessments were in place in areas such as personal care and stoma care which reminded staff on the importance of wearing PPE (Personal Protective Equipment).

Good

Is the service effective?

Our findings

People told us staff were competent and well equipped to support them. One relative explained, "They are well-trained and know what they are doing. For example, [staff have had] gastro training and they are trained in [relative's] new sleep system."

Staff and Shared Lives carers received training to support them in their designated roles. This included topics such as infection control, moving and handling, first aid, nutrition and dignity at work. Specialist training was also provided in topics such as epilepsy, stoma care and equipment specific training when needed. The registered provider had recognised that engagement with training was weak in the shared lives schemes where carers are self-employed. In response, the Head of Quality and Compliance participated in a video production of 'confidentiality training' which was circulated electronically. The registered provider had also begun the roll out of 'train the trainer' training to enable staff to provide refresher training to shared lives carers in their own home.

Staff received regular supervision and an annual appraisal which included annual objective setting to enable any learning or development needs to be identified. Shared Lives carers were supported by an allocated key worker through regular monitoring visits and an annual review. Staff and shared lives carers told us they felt adequately supported and were able to raise any concerns both informally and formally. Shared lives carers told us, "Training is very good. Everything is up to date, if it's running out they remind me", "I'm confident that if I needed to speak to anyone about anything they would be there. Definitely supported well. Everything runs smoothly" and "We have no complaints, if we did I know who to speak to. They are always contactable. There are carers groups if we want to go."

The service was working within the legal framework of the Mental Capacity Act (MCA) 2005. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff sought consent before providing care. One person told us, "Staff ask me first before doing anything." One relative told us, "My relative cannot give any feedback; the staff explain every little thing to him as they go along. They don't do anything without explaining it to him." There was evidence of consent being sought within records for decisions such as photography and information sharing. People signed their own support plans where able. Staff completed mental capacity assessments in accordance with the two stage test and deprivation of liberty checklists were used to examine whether people were being deprived of their liberty.

People who used the service were supported to maintain good health and staff accompanied people to routine appointments when required. Staff made referrals to professionals such as the Community Psychiatric Nurse when deterioration in behaviour was noted. Health passports were in place to ensure important information was transferred across services in the event of an emergency and health action plans were devised for those using the supported living service. Information was contained within care files on

people's nutritional support needs or individual dietary requirements. People told us staff knew about their individual nutritional likes and dislikes. One person told us, "Staff know I only like small portion food. They do that for me."

Good

Is the service caring?

Our findings

People spoke positively about the staff team who supported them. It was evident through speaking to both staff, shared lives carers and people using the service, that genuine relationships had been formed. Comments included, "We are very satisfied with PSS. Staff are very good, regular and reliable", "Staff are kind and caring. I'm treated well", "I feel listened to. I am in control of my care", "The staff know how I like things done" and "I can talk to staff about anything".

People were supported to express their views and be actively involved in making decisions about their care. One person told us, "I have been involved all the way with my plan. For example; likes, dislikes that sort of thing." Care files contained information as to how the person was involved in the compilation of their information and there was evidence of consultation with people. People's views were recorded on care planning review documents and we saw that people contributed to the assessment of their shared lives placement. Some people were involved in the recruitment and selection process of potential shared lives carers to ensure the views of someone who used the service were sought before decisions were made about the suitability of the applicant.

The registered provider had introduced 'video' support plans to enable people to fully participate in the planning of their care and to allow the person to express their goals and support needs in their own words. The registered manager told us how this creative tool had been used to enable a person who was registered blind to engage with their support plan in an accessible format. People's support plans, consent documents, safeguarding and complaints policy were in an easy read coloured format with pictorial tools to explain the contents and purposes. Any barriers to communication were clearly recorded within files such as how to interpret gestures and pitch of voice for those who were non-verbal.

Staff understood how to make referrals to local advocacy services, to enable people to be involved in decision making, where they had no family member or representative to support them. A list of local advocacy service details was maintained.

All PSS staff received mandatory equality and diversity training as part of their induction. Staff were able to describe how they protected people's dignity and right to choose how they wanted their care delivered. One person told us, "We are treated with dignity and respect; for example, when I use the toilet they shut the door. I have showers, they cover me up properly." The service had signed up to the Dignity in Care Charter and we spoke to the manager of the service who was also a Dignity Champion. They explained that their role was to lead on the promotion of dignity amongst the staff team and disseminate good practice information.

Staff worked with the aim of developing people's independence and records outlined what tasks the person was able to do for themselves and what support they may need. One care file instructed staff, 'Prompt and encourage me to do things for myself.' One staff member told us, "It's easy to do everything for people but with patience, you can enable them to do things for themselves and give positive reinforcement to encourage this." This was reflected in the feedback we received from people who used the service. One person told us, "I choose what I want to do and when. I decide when we go out, for example what I want for

my lunch."

Good

Is the service responsive?

Our findings

PSS stands for Person Shaped Support and we were told that the service prides themselves on the implementation of this in their everyday interaction with people. This was evident within the individualised care records we reviewed. Support plans contained detailed information about the individual and how they required their support to be delivered. An 'About Me' document and 'one page profile' enabled staff to access information in respect of the person's background, important relationships, routines, likes and dislikes and provide care based on people's needs and preferences.

People told us that the service met their needs and support was delivered in accordance with their plan of care. One person told us, "My needs are met; I have a plan and have done it with staff." Care plans covered different aspects of care such as health, communication and nutritional needs and advanced care plans were in place to enable staff to have a deeper understanding of specific needs. For example, one person had an advanced care plan for a depressive disorder. Staff were provided with detailed information on how to manage this including; early indicators of low mood and how to support the person according to their wishes, which included the use of humour and a focus on the person's positive achievements.

Support plans were reviewed regularly and any changes to the person's support requirements were well documented. Shared Lives placements were also subject to regular evaluation to ensure they continued to meet the needs of the person. This included monitoring visits every 6-8 weeks and an annual review.

We noted that some care records contained 'goals' set by the individual which included targets such as 'cooking a meal for a family member'. Records contained guidance on how staff were to support the person to achieve their goals and within what timeframe. The registered provider had plans to further embed this system through the introduction of a new 'outcome star' tool. This tool would be used to support people to identify and make progress towards their individual goals in respect of independence and well–being and to enable people's individual progress to be measured in a person centred way.

Staff supported people to access activities within the community to encourage social stimulation and independence. We saw that one person was supported by staff to access voluntary work in the local community. PSS Seel Street comprises part of a parent organisation, PSS. The registered manager highlighted the benefits of this which meant staff could access a variety of resources within the PSS organisation such as day centres which provided activities such as gardening, a sensory room and arts and crafts.

People had access to a complaints policy, which was also available in an easy read format, to enable them to raise concerns about the service. A record was kept of complaints with details of the outcome and any remedial action taken. Complaints were responded to in accordance with the provider's three stage procedure and allocated timescales. We reviewed a selection of recent complaints and saw evidence of appropriate action being taken in response to people's concerns. People felt confident that staff would listen if they needed to raise a complaint.

The service was not currently supporting anyone who received palliative care but had given consideration as to their processes and how they would manage this in a sensitive manner if the need arose. Processes were designed to enable people to express their end of life wishes if they wished and policies were in place to guide staff in this area.

Good

Is the service well-led?

Our findings

We received positive comments about the management of the service. Comments included, "PSS is very good", "The office knows what they are doing. It is organised" and "We are kept informed, the office takes the weight off our shoulders, we feel very lucky. It seems to be running very well." Staff comments included, "It's well managed, they care for everyone including staff, they listen and it's well organised."

The three services we inspected each benefitted from an allocated manager with clearly defined roles and responsibilities. Quality assurance systems were robust and included comprehensive audits in respect of care plans, health and safety, safeguarding incidents and medication. These governance procedures were effective because they were self-critical and identified areas for improvement. For example, quality checks of care files identified missing information and timescales for completion and these were signed off once completed. Further oversight was provided by the Head of Quality and Compliance who undertook regular quality reviews to assess the service in respect of the key lines of enquiry that we inspect. This included the compilation of quality reviews, a self-assessment tool used to score the service and identify areas for improvement.

The overall culture of the service was an emphasis on enablement and empowerment. This ethos was evident in the care records we viewed and staff were able to describe how they applied this in their everyday practice. People told us how staff encouraged their independence within their interactions. One person told us, "[Staff] really encourage me to things for myself."

The registered provider measured the effectiveness of service provision through a series of 'impact reports' which aimed to quantify the positive impact the service had on people's lives. The registered provider told us about their plans for continuous improvement as outlined within their 'Big Plan'. This included the introduction of three-yearly observed practices for staff with a focus on three areas aligned to the values of the service, the roll out of video support plans and the implementation of the 'outcome star'. The service had also signed up to the Driving Up Quality Code as a sign of their ongoing commitment to improving standards of care in learning disability services.

The organisation had a number of different engagement tools in place to enable people to provide feedback on the quality of care being delivered. This included annual satisfaction surveys for people using the service, their relatives, staff, commissioners and Shared Lives carers. This feedback was used to develop and improve the service and actions were formulated as a resulted and circulated through the 'You said, We Did' newsletter. People and Shared Lives carers also attended regular shared voice and shared carer meetings to enable them to contribute towards the shaping of the service. Team meetings were held regularly to promote effective communication and enable any support needs to be identified.

A range of up-to-date policies and procedures were in place to guide and inform staff practice in areas such as challenging behaviour, health and safety and information governance. We saw that a new initiative of 'policy briefings' had been introduced at team meetings to familiarise staff with the contents of these.