Care Quality Commission

Rotherham Doncaster and South Humber NHS Foundation Trust

Domiciliary Care Service

Inspection report

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Ratings

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

Overall summary

The inspection took place on 15, 16 and 17 September 2015 and was announced. The provider was given short notice of the visit to the office, in line with our current methodology for inspecting domiciliary care agencies. This was the first inspection of the service under the Health and Social Care Act 2008.

The Domiciliary Care Service provides personal care to people living in their own homes At the time of the inspection the service was providing support packages to 31 people, who lived in one of four supported living schemes. Some people lived in shared houses and some people lived in their own flats. Most were 24 hour support packages.

The service had a registered manager in post at the time of our inspection. 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.

Before the inspection we received information from a governor of Rotherham Doncaster and South Humber NHS Foundation Trust. The role of NHS Trust governors is to hold the non-executive directors to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public. The information was in relation to the service provided to people in one of the four supported living schemes. These included the level of staff support hours provided, the support staff training in administration of medication people's safety in relation to any inappropriate behaviour presented by their peers, and the use of slings, for people who needed staff support to move using hoists. The Trust governor also wanted to be sure that particular incidents had been addressed properly and learned from to prevent recurrences.

When we visited people in the supported living schemes we saw staff interacting with people in a caring way and it was clear that the people who used the service had developed good relationships with the staff.

During the inspection we found that care and support was planned and delivered in a way that made sure people were safe. There were no current concerns in relation to the numbers or flexibility of the staff support for people overall and all the staff we spoke with were clear that there were enough staff to keep people safe and to meet people's needs.

We found that support staff were adequately trained to administer medication to people safely. We found any errors were investigated thoroughly, learned from, and action was taken to prevent recurrences. Medicines were well managed generally, with room for improvement regarding monitoring and more personalised storage for some people.

We found that people who used the service were kept safe and any risks were assessed and appropriate risk management plans in place, to help support staff to manage and minimise risks. This included any behaviour people might present, which might challenge the service.

Staff had received training in safeguarding people from abuse and all safeguarding concerns were reported to the appropriate professionals, including the local authority safeguarding team and were able to explain their role in safeguarding people.

We spoke with the staff supporting people and with healthcare professionals about the use of slings. They told us that people were not at increased risk of harm from the slings used.

There was enough skilled and experienced staff on duty to meet people's needs. We saw there was a recruitment system in place that helped the employer make safe recruitment decisions when employing new staff. New staff had received a structured induction and essential training at the beginning of their employment. This had been followed by regular updates and specialist training to develop their knowledge and skills.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

The management team demonstrated a good awareness of the Deprivation of Liberty Safeguards and their role in protecting people's rights and recording decisions made in their best interests.

There was good, clear guidance for staff about what people liked to eat and drink and how they needed to be supported, and people were involved in choosing what they ate. People's comments, and our observations, indicated they were happy with the meals provided. We saw specialist dietary needs had been assessed and catered for and people received a well-balanced diet.

People were supported to maintain good health, have access to healthcare services and received on going healthcare support. People had received support from healthcare professionals when required.

People's needs were assessed and care and support was planned and delivered in line with their individual

Summary of findings

support plan. People's support plans clearly identified the areas in which they needed support. People's relatives said that the staff worked hard to provide people with a good lifestyle.

The service had a feedback and complaints management system in place and this was seen as part of continuous improvement. People knew how to raise concerns and we saw evidence that any concerns raised had been dealt with effectively.

We saw that regular quality and safety audits had taken place to make sure policies and procedures were followed.

We saw that the management team had done some work to listen to and involve all stakeholders, and to learn, improve, and personalise the service to people. However, we identified engagement with some people's relatives as an area which required improvement, as there was further work to do on this.

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.

Generally, the provider had appropriate arrangements in place to manage medicines. With room for improvement in monitoring and more personalised storage for some people.

The service had policies and procedures in place to protect people. Staff we spoke with confirmed they had seen the policies and spoke about them in staff meetings.

Care and support was planned and delivered in a way that made sure people were safe. We saw support plans included areas of risk.

The service had safe arrangements in place for recruiting staff.

Is the service effective?

Good

The service was effective.

People were supported to have their assessed needs, preferences and choices met by staff who had the necessary skills and knowledge.

We found the service to be meeting the requirements of the MCA and DoLS.

People were supported to eat and drink sufficient to maintain a balanced diet.

People were supported to maintain good health and to have access to healthcare services.

Is the service caring?

Good

The service was caring.

We saw staff were aware of people's needs and the best way to support them, whilst maintaining their independence.

We saw that the care and support that was provided was person centred and individualised to support people's needs.

We saw staff interacted with people in a positive way while respecting their preferences and decisions.

Staff demonstrated a good awareness of how they should respect people's choices, ensuring their privacy, dignity and independence were maintained.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and support was planned and delivered in line with their individual care and support plan.

There was room for improvement as people were not provided with a copy of their support plan, presented in a way that suited their individual communication needs.

People told us about a variety of activities they were involved in.

Summary of findings

People were made aware of how to raise concerns and systems were in place to manage any concerns received. We also saw advocates were used where people needed someone to speak on their behalf.

Is the service well-led?

Good 

The service was well led.

There were clear messages from the Trust about their values and principles and there was evidence that people were consulted about the service provided. However, there was room for improvement in consulting some people's relatives

We saw various audits had taken place to make sure policies and procedures were being followed.

Domiciliary Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 15, 16 and 17 September and was announced. The provider was given short notice of the visit to the office, in line with our current methodology for inspecting domiciliary care agencies. The inspection was undertaken by a social care inspector.

Before our inspection, we reviewed all the information we held about the service. We asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection and this was returned to us. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Before the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the service. We also obtained feedback from two of the local authorities which commission the service.

We visited four of the shared houses in the supported living schemes. We observed care taking place in the supported living schemes, and spoke with five people who used the service. We observed staff undertaking various activities, including supporting people around the home and helping them access activities and choose meals. In addition to this, we undertook a Short Observation Framework for Inspection in one supported living scheme. (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine members of three support teams, the registered manager and the service manager. We reviewed documentation relating to people who used the service, the staff and the management of the service. For instance, we looked at four people's care and support records, including their daily records, and their assessments and support plans. We saw the systems used to manage five people's medication, including the storage and the records kept. We looked at the personnel files for five staff members, which included recruitment, and training and support records. We also looked at the quality assurance systems to check if they were effective and identified areas for improvement.

We also spoke with five people's relatives on the telephone and met with a governor for the Rotherham Doncaster and South Humber NHS Foundation Trust.

Good

Is the service safe?

Our findings

We spoke with people who used the service and they told us they were happy and felt safe. For instance, one person said, "I feel very safe and the staff are brilliant."

We received queries from a Rotherham Doncaster and South Humber NHS Foundation Trust governor in relation to the level of staff support hours provided, both in the daytime and at night. During the inspection we found that there were no concerns in relation to the numbers or flexibility of the staff support for people overall. We spoke with the registered manager who told us if people's needs or circumstances changed, so if more staffing hours were needed they would be in touch with the appropriate professionals to review the package of support.

At the supported living scheme referred to by the Trust governor we found that the staffing support and the staff roles had changed for people when their care and support as taken over by the Domiciliary Care Service. This had led to some staff leaving, and concerns had been expressed by people's relatives about the level of support available to people. We found that the management team had taken these concerns into account when reviewing the staff support available and there had been an addition of further support staff hours.

At night the support arrangements were based on people's needs. For instance, at one supported living scheme there were support workers awake throughout the night, along with a staff member of a more senior grade, 'sleeping in'. This meant they were available to provide practical help, support and advice to the waking night staff, if necessary. The people we spoke with as part of the inspection, including managers of the service, staff and people's relatives said this was adequate to keep people safe and to meet people's needs.

When we spoke with people's relatives some told us there had been issues with the level of staffing support provided in one supported living scheme, but that this had been addressed and things had improved. One person's relative told us, "There were changes and staff left, so they were using staff from other places to cover and they didn't know people's needs." They went on to say this had now improved, as permanent staff had been recruited.

Another relative commented, "I am really pleased now. There were changes in the staff and that wasn't very good. Then they lost their cleaner and the driver, but they are getting extra support staff in, so there are now more staff. I have been assured that there are enough staff around. Recently, when I have visited I have gone home far happier." Other relatives said, "There were a lot of staff changes. I now worry less as it's improving and it's going in the right direction. I speak to another parent regularly and last time we spoke we both said, "Isn't it nice?" and "There have been changes in the frontline staff and new staff have been recruited. They have increased the staffing."

The Trust had a staff recruitment system, which required that certain pre-employment checks were undertaken before applicants began work. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. We looked at the personnel files for five staff members and found the recruitment policy had been followed appropriately.

We saw records which showed that staff had received training in safeguarding people from abuse. The staff we spoke with confirmed that the service had policies and procedures in place to safeguard and protect people and that they had seen the policies. They told us they always discussed safeguarding people in staff meetings, as it was a standing item on their staff meeting agenda. The staff we spoke with were aware of the Whistleblowing procedure. Whistleblowing is one way in which a worker can report suspected wrong doing at work, by telling their manager or someone they trust about their concerns.

The Trust governor wanted to be sure that people who used the service were kept safe in relation to any inappropriate behaviour presented by their peers. We found that staff had received training in clinical risk assessment and the support plans we looked at included risk assessments and risk management plans. These identified any risks associated with people's care and support needs and provided clear guidance for staff on how to minimise and monitor any risks. Risks were managed well, and thoughtfully, to take into consideration the least restrictive approaches and interventions.

We reviewed all accidents, incidents and safeguarding concerns in the service since registration. We found that if any untoward incidents took place, these were investigated thoroughly, learned from, and action was taken to prevent recurrences. We found that all safeguarding concerns were

Good

Is the service safe?

reported to the appropriate professionals, including the local authority safeguarding team. The registered manager showed us a log of safeguarding incidents, which had been reported to the local safeguarding team and to the Care Quality Commission. The log included a section about lessons learned.

The Trust governor raised a question about the suitability of the training provided to support staff to administer medication to people and one person's relative told us that there had been an incident when their family member had been given someone else's medicine, in error. The person's relative told us that they were satisfied that the incident was investigated, and action had been taken to prevent recurrences. They said, "It was all explained to me and sorted out, and I was reassured that staff were given adequate training and guidance in administering medication."

We looked at arrangements in place to manage people's medicines and we saw that staff responsible for administration of medicines, did so after receiving good quality training, and after an assessment of their competency.

Support plans we looked at included information about how the person liked to be supported to take their medicines. We saw the records of the medicines prescribed for five of the people who were supported by the service. All the records we looked at were up to date and the administration of people's medicines had been accurately recorded. There was a clear system for ordering new medicines and for returning unused medicines to the pharmacy.

Whereas some people's medicines were stored in locked cupboards in their room, this was not the case for everyone. Some people's medicines were stored together, centrally in their shared house. The managers told us they had plans to introduce a more individualised system for those people, and that this would require careful planning for each person.

The Trust governor also raised an issue in relation the use of slings, for people who needed staff support to move using hoists. We spoke with healthcare professionals including a senior physiotherapist, and tissue viability nurse about the use of slings. They told us that the slings used were made specifically for this purpose, that people were not at increased risk of harm and that no one living in the supported living schemes had developed any pressure sores or injuries related to their slings.

The registered manager told us that recently, the service had supported several people to move into their own flats, and that, as part of this process risk assessments were undertaken and assistive technology had been installed. This included door alarms, bed sensors to help keep people safe. These were under review for each person, to make sure the technology in place met people's individual needs and promoted people's independence.

We saw that the control and prevention of infection was managed well. We saw evidence that care staff had been trained in infection control. They were able to demonstrate a good understanding of their role in relation to supporting people to maintain high standards of hygiene, and the prevention and control of infection. We saw that staff wore personal protective equipment (PPE) when delivering personal care and practised good hand hygiene.

We spoke with the staff supporting people and with healthcare professionals, such as a senior physiotherapist and tissue viability nurse about the use of slings. They told us that people were not at increased risk of harm from the slings used, which were made specifically for the purpose.

Good

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and they told us they thought the staff were competent and well trained to meet their or their family member's individual needs. For instance, one person's relative said, "The staff are well trained."

Staff were provided with core training along with other more specialist training, designed to help them to meet people's individual needs. Most staff we spoke with confirmed that they attended regular training to make sure they had the skills and competencies to meet the needs of the people who used the service. The records we looked at confirmed staff had attended training in all core subjects

One care worker said, "I've had training in every area imaginable that's relevant to my work. We get a lot of training"." Another care worker said, "The Trust let us know about training courses all the time."

There had been limited training opportunities for the members of one supported living team because of changes in staff, and the team had focussed on maintaining consistency for people who used the service. The management team were aware of this and were addressing the issue by taking opportunities to bring training to the team.

The registered manager told us all staff completed a comprehensive induction which included, care principles, service specific training such as, equality and diversity, expectations of the service and how to deal with accidents and emergencies. Staff were expected to work alongside more experienced staff until they were deemed to be competent.

The registered manager told us that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Support workers were regularly observed at work, by their supervisors as part of their professional supervision. This was to make sure they adhered to good practice in interacting with people. Written records were kept of these observations and included whether the staff member preserved people's dignity, privacy and confidentiality, and if they sought and took into account people's wishes when delivering their care and support.

Staff we spoke with told us they received formal staff supervision and appraisals, which were called personal development reviews. Supervisions ensure that staff receive regular support and guidance with their managers. Appraisals enable staff and their manager to discuss any personal and professional development needs the staff member may have.

The Care Quality Commission is required by law to monitoring the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights. The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

We checked whether people had given consent to their care, and where people did not have the capacity to consent, whether the requirements of the Act had been followed. All the staff we spoke with were clear that when people had the mental capacity to make their own decisions this would be respected. Care staff we spoke with had a good awareness of the MCA. They confirmed they had received training in this subject to help them understand how to protect people's rights.

There was evidence of good and creative practice in involving people in decisions about their care. Where people that used the service had limited capacity, their family or representatives had been involved in their care plans. People had mental capacity assessments, to identify their ability to make choices on a day to day basis and the best interest process was used for making decisions when people had been assessed as not having capacity to make a particular decision. People had used Independent Mental Capacity Advocates (IMCAs) when necessary. The management team demonstrated a good awareness of the Deprivation of Liberty Safeguards and their role in protecting people's rights and recording decisions made in their best interests.

Good

Is the service effective?

One person's relative we spoke with felt that barriers had been put in their way by managers of the service, when they advocated for their family member to spend their money on nice things for themselves. They said they would like to be more involved in future meetings, where best interests decisions were to be made about their relative's finances. We passed this to the management team, who said they would ensure this relative's concern was acted upon.

The information in people's assessments and plans was detailed, and provided information for staff on how they should support people to make and communicate their own decisions. However, it was not always made clear in people's files when others involved in their lives had the authority make decisions on people's behalf, such as appointees or Power of Attorney (PoA). Powers of Attorney confirm who has legal authority to make specific decisions on a person's behalf when they cannot do so for themselves. These may be in place for financial affairs and, or care and welfare needs. It is important that staff have this knowledge to make sure only those with the right authority make decisions on people's behalf.

We asked one person using the service about the food available to them. They told us they always enjoyed the food, and told us they could pick what they wanted. Another person used signs to indicate to us that they enjoyed their meals.

There was good, clear guidance for staff about what people liked to eat and drink and how they needed to be supported. There was evidence of people having choices and of them being supported to eat healthy meals. There was also monitoring where necessary. Meals were flexible to meet the needs of the people who used the service.

Some people were supported to shop for and cook their own meals, while others required more support from staff, who cooked, while involving people in ways that suited their particular needs.

People were supported to eat and drink sufficient to maintain a balanced diet. Some people required support from other professionals in relation to their dietary needs. Appropriate referrals had been made, for example some people had involvement from a speech and language therapist, as they had swallowing difficulties.

One relative we spoke with said the manager and staff in one particular supported living scheme were working hard on making food more appetising for people who had a pureed diet, and were seeking training courses to help with this. Another person's relative said, "I visit every week. On one occasion, there were staff I did not recognise. (My family member) needs a soft diet was not given an appropriate meal. They also left another person with food around their mouth. I raised this with the permanent staff the next time I visited. Recently though, there was a new staff member who was very nice, and who went out of their way to make themselves known to me. They had gone to a great deal of trouble to present (my family member) with a meal that met their needs and was really well presented.

Each person had a health action plan and records showed there was lots of good support to people to help them access appropriate healthcare services. The records we saw showed that people had access to a range of services, including, a GP, psychology, psychiatry, speech and language therapy, occupational therapy, specialist nurses, such as tissue viability and diabetic liaison nurses. Good, clear monitoring records were kept of people's hospital appointments and other contact with healthcare professionals.

Good

Is the service caring?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People who used the service and their relatives told us that the managers and staff who worked in the service day to day are doing their best, worked really hard and were generally, 'Very good'. One person that used the service said, "The staff who support me are excellent,." One person's relative said they had a good relationship with the staff and felt that the care their family member received had always been of a very good standard. They said, "The staff are fabulous. They always put (my family member) first. They are very good at their jobs. (My family member's) clothes are always lovely."

Another person's relative said they felt involved in their family member's care and was aware of their care and support plans. They added, "The care is good, people are well cared for and their clothes are always immaculate."

On the day of our inspection we saw staff interacting with people. We saw staff supported people who used the service in a very professional and caring way. It was clear that the people who used the service had developed good and strong relationships with the staff. A member of staff said, "We work in teams, and with the same people. So we get to know people and their needs, likes and dislikes."

The service supported people to express their views and be actively involved in making decisions about their care and support. People were involved in their support plans, which included their views and choices. They gave a clear picture of people's needs and identified the support that they required. The plans had been developed in a person-centred way, so they included people's likes and dislikes. For instance, one person's records included their preferences in relation to skin care products, food and leisure activities. Staff we spoke with were knowledgeable about these preferences.

Where people used limited verbal communication, the plans included descriptions of how to support people to communicate their choices. We saw evidence in people's files that they had been involved in care planning and reviewing their care, and pictures and symbols had been used to enhance people's understanding. Most written information was provided in ways that suited people's individual communication needs. For instance, in plain English and large print, or an 'easy read' format. Staff told us they also read and explained things to people.

Their plan also recognised the support that the person needed from particular family members and other professional services, including GP's and hospital specialists. People were also supported to maintain friendships. For instance, people's support plans included information about their circle of friends and who was important to them.

We were told that staff supported some people to go to church so that they could practice their faith and we saw there was information in people's files relating to their beliefs.

Each person had a named member of staff assigned to them who worked with them closely, and a 'special interest person' ensured the person received appropriate care and support and supported the person with values such as privacy, dignity, independence and choice. Discussion with staff members showed they clearly understood the needs of the people they were supporting. All of the staff we spoke with had a very good understanding of people's individual needs and of how they chose to have their care delivered.

We spoke with staff who were knowledgeable about maintaining people's privacy and dignity. One care worker said, "This is people's home. We are always aware of that and we try to involve people in decisions." Another person said, "We always make sure curtains and doors are closed when delivering personal care." All the people's plans we saw described how people should be supported so that their privacy and dignity was upheld. We checked each person's daily notes, where staff had recorded how they had provided support. The daily notes showed that staff provided care and support in accordance with the way set out in people's care plans and risk assessments, ensuring their privacy and dignity was upheld.

Good

Is the service responsive?

Our findings

One person we spoke with told us they were very pleased to be supported by the service and that staff were supportive and encouraged them to be independent. They said, "The staff are brilliant." Another person was also very complimentary about the staff and the service and said, "It works for me."

People's relatives said that the staff worked hard to provide people with a good lifestyle. For instance, one relative said. "(My family member) has a good life." In one supported living scheme, one person's relative said that although there had been some changes, "It has been nice to see more male staff members in the team. It's getting back to how it was."

People's needs were assessed and care and support was planned and delivered in line with their individual support plan. Some people's support plans included pictures to assist in the person's understanding and being involved. Where necessary, people also had summaries of their care and support needs with pictures. These included areas such as 'looking nice and clean', 'seeing people I know', 'keeping safe', 'going out' and 'how I tell others how I feel and what I like'. Support plans clearly identified the area of support along with aims and objectives the person wanted to achieve. For example, one support plan aim was to transfer the person comfortably by trained staff using the appropriate equipment. The plan indicated what equipment should be used and gave clear instructions for staff to follow.

We found that people's care and treatment was in general regularly reviewed to ensure it was up to date. People had the opportunity to discuss their support plan with staff, on a regular basis. Staff we spoke with felt people were consulted about their plan and were able to contribute. We saw that people had and 'My review' documents, which included things they would like to change, things they would like to stay the same and their hopes and dreams. However, people did not have their own copy of their support plan or their review in a format that suited their needs and preferences.

People had very diverse interests and abilities and engaged in a variety of activities that suited their particular needs, including using specialist day services, going out to the park, shopping, gardening, going to the gym, swimming and going to shows and concerts. This was confirmed by talking to the staff and looking at people's individual care and support plans.

People in each supported living scheme had meetings and these were held every month. Staff felt these meetings helped to identify how the service could improve what support they offered to people. People also attend a 'focus group' meeting monthly. The group included representatives from all of the community services within the Trust. We saw the minutes of the last meeting. People had looked at an easy read version of the 'Dignity in Care' document. People who attended had commented about how they wanted to be treated as an individual and be involved in decisions, to enhance their dignity. The focus group minutes included an action planner, and they were fed back at the staff meetings held within the service, to make sure that what people said was acted upon.

The service had a feedback and complaints management system in place and this was seen as an integral part of continuous improvement. People knew how to raise concerns and we saw evidence that concerns had been dealt with effectively. We also saw advocates were used where people needed someone to speak on their behalf.

The service kept a log of complaints received along with very detailed accounts of investigations, any actions taken and any lessons learned. We spoke with the registered manager who said, "We use complaints and comments to improve the service." The complaints procedure was available in an 'easy read' version. People we spoke with told us they would talk to staff if they had a worry, and felt they would sort it out.

Comments from people's relatives included, "I have always had a good dialogue with staff and managers and have discussed things. As far as I'm concerned, I have no complaints" and "If I did have any issues I would take it up with the manager. I have done before, and I have been reassured that they learn from things."

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission. The registered manager was supported by a team of locality managers who were responsible for the day to day running and management of the supported living schemes.

We saw audits had taken place to make sure policies and procedures were being followed. One person's relative said, "There is always someone checking up and auditing to see that things are alright."

The provider told us that the service undertook 'Total Quality Managements' audits on a regular basis and these were to make sure that good practice was being achieved in care delivery,health and safety and staff management. Where areas were identified for improvement an action plan was put in place, which the supported living team managers were responsible for implementing. The registered manager visited each supported living service regularly to check progress with the action plans. The locality manager also undertook unannounced monthly visits and also completed checks on people's satisfaction with the service, staffing levels, and progress with action plans.

The registered manager told us in their PIR that a number of meetings took place regularly to make sure quality of the service was maintained, that communication was effective throughout the teams, and to enable the sharing of good practice and of any lessons learnt. These included, staff meetings, community homes service managers' meetings, and quality circle meetings, with a representative from each team. The records we saw confirmed this.

Staff told us meetings took place regularly and they were able to contribute ideas and suggestions to develop the service. Staff confirmed they knew their role within the organisation and the role of others.

The registered manager told us that the Trust also used a number of methods to keep people who used the service and staff up to date with what was happening in the Trust and with good practice developments. These included, a service user newsletter, a staff and members' newsletter, practice development bulletins, a publication which outlined areas for learning and improvement identified by the Trust, and health and safety notices. Staff also had access to information on the Trust's intranet site.

People, their families and other stakeholders were asked to fill in satisfaction surveys, and people's satisfaction with the service was always discussed at service user meetings. We found there were clear messages from the Trust about their values and principles. These were about being reliable, caring and safe, empowering and supportive of staff, open, transparent and valued, and progressive.

We spoke with people who used the service and their relatives about the management of the service. One person's relative told us, "The senior managers in the organisation have good principles. Things have improved since they started listening more and taking more notice about the way the service was being managed."

In one supported living scheme three people's relatives told us there was room for improvement in consulting and involving people's relatives about the running of the service. For example, they told us several people who used the service did not have capacity to make informed decisions and, although things had improved, there was not enough dialogue between the managers of the service and people's relatives and representatives.

They told us that a management decision was made about the way staff should support people at mealtimes. No information had been provided about why the change was necessary and people's close relatives were not made aware of the change until after the event.

We saw that the management team had done some work to listen to and involve all stakeholders, and to learn and improve the service to people. However, we identified engagement with some people's relatives as an area for improvement, as there was further work to do on this. We discussed with the management team, 'Listening Events' for the one supported living schemes where big changes had taken place, to look at what went well and what did not go well, to take forward learning for the future.