Aspects Care Limited

Aspects Care Limited - Grimsby

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection of Aspects Care Limited – Grimsby took place on 13 and 15 June 2018 and was announced. We gave the provider notice of our inspection because we needed to know someone would be at the agency office to meet us. At the last inspection in December 2015 the service was given and overall rating of 'good', with the well-led section rated as 'requires improvement' due to there being no registered manager at the time. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service to at least 'good' in the key question 'is the service well-led?'

At this inspection we rated the service as 'requires improvement'. This was because care had not always been taken with recruitment processes, staffing levels were too reliant on care coordinator cover and the management of the service was not as efficient as it might me. However, there was a newly registered manager who had been in post for the last two months and the provider was no longer in breach of their registration requirements in this regard. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

Aspects Care Limited – Grimsby located in the town centre of Grimsby in North East Lincolnshire has an office on the first floor of a privately rented building. The building offers a lift to all floors and provides car parking spaces to the front.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults and younger disabled adults. The service was supporting 15 people at the time of our inspection. Five of these people live in their own homes. Six people live in their own 'supported living' flats in Willow House, Crosland Road and four live in a shared bungalow on Station Avenue, all of which are in the Grimsby area. People that live in supported living have tenancy agreements with their prospective housing associations. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living and therefore this inspection looked at people's personal care and support.

This service provides care and support to people living in two '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.

Not everyone using Aspects Care Limited – Grimsby receives regulated activity; 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.

The care service has been developed and designed in line with the values that underpin the Registering the

Right Support and other best practice guidance, with regards to the supported living houses. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At this inspection we found that staff recruitment processes were rushed so that the service sometimes let people start shadowing before their checks were through and references were often received via the telephone or were testimonials only. We made a recommendation about this.

Staffing numbers were insufficient as delegation of work tasks were unequal, with care coordinators taking up visit duties to ensure everyone received the support they required. This was because the two care coordinators employed were frequently covering staff sickness and visits that could not be allocated to support staff. There was also some inconsistency in the timely compilation of staffing rotas. While people had not been at risk or experienced any harm, it was clear that staffing numbers were insufficient at times of unforeseen circumstances to cover the number of care packages that the agency was allocated. We made a recommendation about this.

The provider's quality assurance system was not always effective at identifying shortfalls in the service. Audits, satisfaction surveys, meetings, and spot checks on staff were carried out, but they were not extensive enough to cover all areas of practice. Nor were the findings of the quality assurance system formally analysed and reported on. We made a recommendation about this.

People were protected from the risk of harm and staff were trained in and knowledgeable about safeguarding people from abuse. Risk was safely managed. The management of medicines was safe and systems in place demonstrated there was an effective audit trail for handling all drugs. Staff followed good hygiene for safe infection control and prevention. Systems in place acknowledged and recorded when things went wrong and lessons were learnt to ensure problems or mistakes were not repeated.

Staff encouraged people to make choices and decisions wherever possible to exercise control over their lives. People were cared for and supported by qualified and competent staff who were themselves regularly supervised and received annual appraisals of their personal performance. Staff respected the diversity of people and met their individual needs. People's nutrition and hydration needs were appropriately supported to aid their health and wellbeing.

People's mental capacity was appropriately assessed, but by the local authorities that contracted packages of care. Their rights were protected even though the service did not carry out its own capacity assessments. People were supported to exercise choice and control in their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves. The registered manager followed the 'best interests' route where people lacked capacity to make their own decisions. Consent for support to take place was respected so that staff always sought people's cooperation and agreement before completing any support tasks.

People were supported with compassion by kind staff who knew about people's needs and preferences. People were involved in their care and their right to express views was respected. Wellbeing, privacy, dignity and independence were also respected. This ensured people felt satisfied and enabled to make choices regarding their lives.

Support plans laid the foundations for good care. They reflected people's needs well and were regularly

reviewed. People were encouraged to maintain family connections and support networks and their communication needs were assessed and met. An effective complaint procedure in place ensured people's complaints were investigated without bias. The service sensitively managed people's needs with regards to end of life preferences, wishes and care.

The culture of the service was friendly and caring, which ensured good outcomes for people, but it was not inclusive of or empowering for people and staff. This was discussed with the Nominated Individual, who had already identified some areas for improvement in the management systems being operated, and was providing support to the manager. The registered manager understood their responsibilities, but practiced a management style that was not always based on shared responsibilities or included everyone employed at Aspects Care Limited – Grimsby in the running of the service. The registered manager aimed to achieve continuous learning and good practice. The service fostered good partnerships with other agencies and organisations.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment processes and staffing numbers were not always sufficient to ensure safe practices were followed.

Safeguarding people systems were followed and protected people from harm. Risks were appropriately managed.

Medicine and infection control management systems ensured people were protected from errors with medicine administration and poor hygiene practices.

Lessons were learnt to enable improved practice.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised to provide the support people required.

Staff respected people's diverse needs. They supported people with nutrition and health care needs.

People's mental capacity was appropriately assessed and monitored. People's consent was required before any support was provided.

Is the service caring?

Good

The service was caring.

People received support from staff that were kind and caring.

People's views and rights were respected. Their dignity, privacy and independence were also respected.

Is the service responsive?

Good

The service was responsive.

People's support plans reflected their needs and were regularly reviewed.

Family connections, support networks and good communication was encouraged.

People's complaints were satisfactorily managed.

People were well supported at the end of their lives and family members were sensitively responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems were not always effective or extensive enough to highlight quality matters.

There was a positive culture, but inclusion in the running of the service did not always extend to everyone.

The registered manager aimed to achieve continuous learning and fostered good partnerships with other organisations.

Aspects Care Limited - Grimsby

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 13 and 15 June 2018 and was announced with 14 hours' notice given, as we had to make sure there would be someone at the agency offices to see us. Inspection site visit activity started on 13 June 2018 and ended on 15 June 2018. It included a visit to the location premises, speaking to people that used the service and staff on the telephone and viewing records and documentation held by the provider.

One inspector carried out the inspection. Information had been gathered before the site visit from notifications sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We received information from local authorities that contracted services with Aspects Care Limited – Grimsby and reviewed comments from people who had contacted CQC to make their views known about the service. We received a 'provider information return' (PIR) from the provider. A PIR 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 spoke with three people that used the service, two relatives, the registered manager and Nominated Individual. We spoke with six staff that worked at Aspects Care Limited – Grimsby. We looked at care files belonging to four people that used the service and at recruitment files and training records for ten staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring system and the management of medicines. We also looked at records held in respect of complaints and compliments.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe receiving care and support from the staff that visited them or worked with them in the supported living houses. They said, "I trust the staff and know they would never harm me", "Staff keep me and my belongings safe", "I rely very much on staff protecting me", "I've not had any missed calls, though sometimes staff have been a little late or replaced by the coordinators" and "I am confident staff supervise my medicines safely."

Recruitment systems and procedures were robust but had not always been followed sequentially and thoroughly to ensure new staff were suitable for the job. Appropriate Disclosure and Barring Service and other security checks (references and eligibility to work in the UK) were undertaken, but new staff had sometimes started shadowing other staff before these were completed and working in the service before their inductions, which were completed in one day, were finalised. This meant the recruitment process was rushed and the provider could not be certain it was safely followed to protect people from the risk of harm. For example, records showed that three staff members competed their induction and carried out shadowing shifts in a day, another staff member only had testimonials for references and a fifth staff member was employed using only telephone references which had not been dated.

These findings were discussed with the nominated individual and human resources manager who were carrying out a monitoring visit at the same time we inspected. They gave assurances that the recruitment process used recently would be looked at to determine if poor practice had arisen and their findings would be fed back to us. They assured us action would be taken to improve the way the recruitment process was followed in future.

Staffing levels were determined and changed according to the level of care and care hours that people required. However, sufficient numbers of trained and qualified staff were not always available and on duty. Though the registered manager used rotas to meet people's needs these were not produced in a timely manner or included enough staff to respond to any unforeseen circumstances. People and staff told us that on occasion visits were missed and had to be picked up by the care coordinators, but this meant they worked more than their contracted hours. The care coordinators told us they had done this for some weeks, as well as covered the out-of-hours on-call rota and were feeling tired and overworked.

The nominated individual was made aware of this by the two care coordinators, who then explained the issues to us. The nominated individual discussed this further with us and informed us that the concerns about staffing cover were already being addressed internally. They gave a verbal assurance that strategies were being implemented to ensure cover was sufficient going forward and that use of agency staff would be introduced until new staff were recruited. We recommend the provider monitors staffing levels and agency cover at times of unforeseen circumstances.

Staff protected people from avoidable harm and abuse, with systems in place to monitor incidents. They were trained in safeguarding people from abuse and demonstrated good knowledge of the procedures to support this. People and staff were comfortable raising safeguarding concerns and responses to these were

appropriately managed. Staff recognised risks or unsafe situations and people were encouraged to manage positive risk taking to ensure they were in control of their lives. Risks, for example, with people's environments were assessed and information about risk was shared with the care coordinators and monitored as necessary. The supported living premises and equipment used was regularly monitored and maintained for people's safety. Accidents and incidents were recorded, analysed and learning from them was used to avoid repetition. Staff held meetings and handovers to share information on risk and safeguarding, within the two supported living houses.

Staff responsibility for the management of medicines was safe and met good practice standards described in relevant national guidance, including non-prescribed medicines. People were involved in regular medicine reviews. People were supported to safely handle and dispose of their medicines within a shared culture of responsibility. Staff followed correct procedures regarding anyone requiring medicines covertly because of their inability to understand the importance of taking them. We saw some archived medication administration records and assessed that staff maintained accurate accounting for people's medicines.

The service managed the control and prevention of infection well. Staff had received training in this area, understood their responsibilities and maintained appropriate standards of cleanliness and hygiene. One person had a very compromised immune system and extra vigilance was required from staff when supporting them with personal care and food provision. It was essential that personal protective equipment was used by the staff. Procedures were followed and concerns about wellbeing in relation to hygiene were shared with the appropriate agencies. Staff had completed food hygiene training, were experienced and followed required standards and practice.

Staff were open and transparent with regards to concerns on safety. When incidents or accidents happened the registered manager and staff used the experiences to learn lessons so that these did not reoccur. Examples of this included when a medicine expiry date had passed and the person taking it could not be sure it was effective. Staff put new auditing measures in place to ensure this did not happen to anyone else and care coordinators regularly checked expiry dates on medicines during staff 'spot checks'. Similarly, when issues arose with safeguarding a person's finances staff ensured audits were rigorous to protect the person and others from the risk of financial abuse.

Good

Is the service effective?

Our findings

People told us the service was effective at meeting their needs. The said, "All my care is how I like it. Staff always ask me what I want doing next", "I get plenty of help with personal care: showering and that, and it is always how I want it to be" and "The staff are skilled to do their jobs." One person said, "Some staff bend over backwards to assist me and I really don't know what I would do without them."

People's care and support needs were assessed by the local authority that sourced people's packages of care. The service then used these assessments and other information from people and relatives to determine the actual support plan and level of care the staff at the agency would provide. Care and support was planned and monitored to ensure consistency, in line with current guidance, legislation and best use of technology. Reference was made to external services where necessary, such as those for health care and support with technological aids.

Staff were trained and competent to carry out their roles. Aspect Care Limited supplied training to its workforce through its own training company, Aspects Training Solutions, based in Birmingham that sourced Qualifications and Credit Framework apprenticeships and accredited qualifications. This training was in the form of e-leaning and workbooks as well as hands on courses for practical instructions, for example, moving and handling and 'low arousal and personal safety' (behaviour management). Staff training was monitored and there were opportunities each year for staff to update their learning. Supervision and appraisal of staff was effective at motivating them and enabling their individual development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making specific decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take these decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were assessed as lacking capacity to make specific decisions any made on their behalf were done so using best interest processes. Staff were aware of these processes and requirements under the MCA. The procedures for this with regards to people that live in their own homes are called Court of Protection orders.

People were involved in decisions about their care on a day-to-day basis. However, mental capacity assessments were not completed as we saw no assessment documentation held in people's files and the registered manager explained they did not routinely complete them. They told us that the placing local authority completed mental capacity assessments, but for people that paid privately for the service this was not always carried out. The service would benefit from having copies of mental capacity assessments to show how it accounts for the support people receive and how they are assisted to reach decisions about

their care and treatment.

People were asked for their consent with all aspects of the service delivery and this was recorded and signed for, with regards to, for example, taking photographs, handling finances and medicines, receiving personal care, sharing confidential information with other stakeholders when necessary and being visited each month by a care coordinator.

Where people lacked capacity for specific decisions they were given information in an accessible format and family, friends and advocates were involved in the process to make decisions that met their best interest. Some people living in the supported living houses had family members with lasting power of attorney status for finances and care. Staff felt that sometimes these arrangements did not benefit the people they supported, as on occasion people were not given full rights of access to their finances or choices. These concerns were being discussed with the local authority safeguarding team and social workers and staff were endeavouring to represent people in the most effective way.

People were actively involved with meal provision and exercised choice regarding food and drink, especially those living in the supported living houses. Discussion with the staff revealed that people were provided with meals that respected their religion, culture and dietary preferences. People, especially those with complex needs, were protected from the risk of poor nutrition, dehydration and swallowing problems that affected their health. For example, one person with a compromised immunity system was given support that had to follow very high standards in food hygiene. Other people prone to making poor choices with dietary intake were supported to eat healthily and were offered advice and encouragement. People's food and drink choices were respected wherever possible.

People's health and wellbeing was effectively supported and monitored. Staff in the supported living houses had responsibility to remind people and arrange their annual health checks to ensure regular monitoring, for example, by doctors, dentists, opticians, audiologists and chiropodists. Staff supported people to attend health appointments. Concerns were identified so that they could be given the right information in the format they required and be supported to return to good health. Patient passports were consistently and effectively used to ensure health needs were understood across services. Advocacy services were accessed where needed.

People that lived in their own homes had full responsibility for the design and layout of their properties and staff only made suggestions for everyone's safety where necessary. People that lived in supported living houses were offered more advice and support to maintain a suitable environment. The responsibility for suitability still lay with the housing provider.

Technology and equipment was sourced to assist staff in the effective support of people with physical needs and those living with dementia, so that they maintained independence while ensuring their best interests. These included hoisting equipment, key safes, some tele-care products (if needed) and grab rails, profiling beds and personal mobility aids.

Good

Is the service caring?

Our findings

People and their family members told us they found the staff to be kind, caring and thoughtful. They said relationships between people and staff were positive. People told us they felt listened to and knew how to seek help. They said, "Staff help me and are kind", "Staff are very respectful", "This is a blinking good agency" and "Staff communicate with me very well." One person said, "I receive a good service and my partner also feels valued, as their well-being is also considered by the staff." A relative said, "Communication is perhaps one area the service could improve on, but otherwise my family member is treated with dignity and respect."

Staff told us how they treated people with kindness and expressed how they exercised compassion for people that were ill or worried about something. Staff demonstrated they had skills to get to know people and said they sometimes had time to spend with people during their calls to provide support and personal care. Staff in the supported living houses spent longer periods on shift with people and so got to know the people they supported there much more easily. They told us they used people's preferred means of communication to interact with them and to provide support with, for example, personal care, nutrition and personal safety.

Staff told us they treated people as individuals and were quick to respond to any changes in their needs. They said they recognised when people needed help from them or their families with decisions about care and support and provided this sensitively. They told us they pointed people and families in the right direction if outside help was needed, for example, from advocates, social services or health care professionals, to ensure people's overall wellbeing.

We saw that staff were asked questions at interview and completed a questionnaire, which reflected the qualities being looked for in candidates to show they were caring and compassionate people. Questions covered how candidates would consider people's needs when planning activities, respecting dignity when giving personal care, recording information and encouraging independence, literacy and numeracy.

People were treated with dignity and respect and they received care that respected their difference and diversity. Staff noted and reported how people were treated in daily logs, which highlighted any issues that other staff or people might raise, so that discussions could be used to find solutions.

Staff had time in their roles to develop relationships with people and family members, which enabled them to recognise and know about when people were distressed or in discomfort. Staff were mindful of people's individual needs and told us how they liaised with people and family members to understand people's preferences and wishes.

People's choices of daily living were respected, including when they moved around their homes or the supported living houses, the time of day they got up or went to bed, whether they required support with personal care and which staff member they received support from. For example, one person told us they had not got on well with a staff member and a conversation with the registered manager ensured they did

not receive support from them again.

Staff respected people's privacy and dignity and maintained confidentiality of information, supplying details to other stakeholders and professionals on a need to know basis only. However, one person we spoke with felt that sometimes staff and care coordinators didn't always think about what they were saying and let confidential information about themselves, other staff and the running of the service slip. For example, one person told us they knew about the rota issues and some staffing concerns, though they also said that staff were respectful and mindful of service users' details.

Good

Is the service responsive?

Our findings

People and their relatives told us the staff responded well to meeting people's needs and they knew how to represent themselves or their family members if not. People said, "Everything is alright and if I were unhappy I'd talk to the staff", "I have made formal complaints and though it took a while for me to be fully confident in the staff, I now find them satisfactory" and "Sometimes you don't get to know what is going on with who is visiting, but usually you know." Relatives said, "There have been problems in the past and when my family member first began to receive a service, but now things are much improved" and "The care coordinators come round now and check that everything is alright for [Name]."

People, their families and advocates were involved in compiling people's care plans and their diverse needs were considered on the grounds of the protected equality characteristics. Their choices and preferences were listened to. For example, one person with a learning disability chose the meals and foods they ate at their supported living house and while these might have been unwise choices they were respected. Staff said this was facilitated because they ate sensibly when regularly visiting their family several times each week. Family members determined the foods they ate at these times. This enabled them independence to exercise choice when they were at home.

Support plans adequately assessed and recorded people's needs. They contained sufficient detail to enable staff to provide the support people required. For example, they showed peoples' personal care needs and their social expectations, which were written in a clear format: routines of the day and night, guidance documentation and risk assessments. Guidance included, for example, prevention of overindulgence with food, avoiding and dealing with choking, managing finances and assisting with mobility and transport.

Support plans explained people's capacity status for making decisions and understanding consequences of their actions. They described people's particular behaviour that would indicate their anxiety and how this could be avoided or reduced. They explained people's preferences and wishes for self-care or support, socialising and activities of living. They described people's communication, nutrition, health and medication requirements as well as their 'hopes and dreams'. Some support plans were extremely detailed and precise in the instructions and information supplied by relatives. They were regularly reviewed against people's changing needs.

Staff encouraged people to make choices so they were in control of their lives and maintained independence. Staff facilitated activities, relationships and community links for those that lived in the supported living houses, so that people were not isolated. Where people experienced barriers to accessing services, staff made reasonable adjustments and action was taken to remove these in relation to communication and access needs.

The provider complied with the Accessible Information Standard (AIS), which aims to ensure that those with a disability receive accessible health and social care information. They achieved this by identifying and managing people's communication needs and where necessary introducing or using technology and aids to assist people and staff with communication needs. For example, some people in the supported living

houses used picture exchange communication systems.

People and their families were given information about how to raise any concerns and give feedback about their care. They told us felt confident their complaints would be taken seriously, explored and responded to in a timely manner, as the complaint procedure was open and transparent. Learning from complaints was used to improve the service and staff gave examples of how they had done this. For example, one care coordinator told us how they had successfully managed to build good relationships with one person's family members after they made several complaints about the lack of very high standards of care, which they expected to be met.

Staff involved people and their relatives by listening to them and informing them of information appropriate to the development of their care plans with regards to their preferences and decisions for end of life care. The process included support from appropriate professionals. Staff were aware of people's diagnoses and skilled in assessing and supporting their learning and physical disability or dementia needs. People's wishes were known and respected, particularly in relation to their diverse needs on the grounds of protected equality characteristics. Assessment of needs looked at people's religious, cultural, physical and marital requirements with regards to end of life care. Staff made sure people's dignity and comfort were maintained and that professionals were consulted about a dignified and pain-free death. Specialist medicines were accessed via contact with people's doctors and district nurses at short notice and staff supported relatives after a person died.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service was well-led, there had been some early teething problems under the new registered manager but that issues were always readily resolved. They said, "I know there have been problems for some staff, but the new manager is still settling in", "I think there just needs to be more information shared with us" and "The staff are doing a good job now and rallying round, so that [Name] gets the care they need."

During the inspection we found that the service was not always consistently well-led and managed because evidence showed that there were other reasons for the well-led section to be rated as 'requires improvement'. Quality assurance systems in place included the use of surveys and audits, but were not as effective as they could have been, recording was not as accurate as it could have been and the management style was not inclusive.

For example, new quality assurance systems in place since February 2018 for improved robustness showed that some audits were carried out by care coordinators, some by the registered manager and some by senior management. The frequency of these had improved. Care coordinators completed 'project visit forms' and supervision checks. The registered manager carried out audits of accidents and incidents and staffing hours. Senior management facilitated satisfaction surveys and monitored health and safety checks. However, quality monitoring information was not collated effectively, recorded and passed to the registered manager so that it could be used to determine improvements needed in service delivery.

We were provided with a recruitment and training matrix (record) which stated that three staff needed a DBS. We had already evidenced that one of these named staff had a DBS check in place. Either recording systems were not kept up-to-date or the poor adherence to the recruitment procedures were the cause of inaccurate information being held. The quality assurance system should have identified either of these shortfalls.

The provider was required to have a registered manager in post and on the day of the inspection the manager had been registered for only two months. This meant they were new to the service and had yet to establish any significant changes.

The new leadership, governance and culture of the service aimed to achieve good person-centred care. The registered manager understood their governance responsibilities with regards to legal requirements and conditions of registration. They wanted to achieve a service where quality performance, risk and regulatory requirements were effectively monitored and mitigated. However, the service was still in a transitional stage following the appointment of the new registered manager who was building up service user and public confidence in the agency.

The management style of the registered manager was amiable, relaxed and progressive. We found that the registered manager took ownership of the running of the service and often chose not to delegate responsibilities to others. However, we saw that this sometimes meant these responsibilities were not

always fulfilled or the best outcomes achieved. We found that the registered manager was well supported by the organisation's senior management team, as the nominated individual and head of human resources visited them on the day of our inspection. We understood this was a regular occurrence throughout the year to carry out audits or provide supervision.

The nominated individual explained that support was being provided to the registered manager by another manager in the organisation acting as a mentor to assist with their growth and development. They told us management systems were being addressed so that responsibilities would be delegated and shared more effectively across the team. For example, care coordinators will take on responsibility for compiling rotas a month in advance so that staff have more notice of their duties. Staffing grievances will be reported more readily to the human resources team for dealing with at organisational level. Staffing hours are to be more contracted for all staff so that their time is used more efficiently.

We recommend the provider ensures the registered manager is equipped to manage the service more effectively and follows good practice guidance already established.

The registered manager strove to engage with staff, people and other stakeholders and shape the culture by promoting the organisation's visions and values. They were supported in this by the care coordinators who had worked some years for the organisation and had experience running a domiciliary care agency. The management team monitored staff practice against the organisation's values through regular supervision. Staff were aware of the visions and values of the service.

Equality and diversity were actively promoted within the service so that people's specific needs under the protected characteristics of the Equality Act were met without discrimination. Staff received equality and diversity training and there were equality champions among the workforce.

Any workforce inequality was acted on so that staff felt they were treated equitably, although sometimes challenges in staff management occurred before consensus and harmony prevailed. For example, it took a staff grievance to resolve a dissatisfaction. The care coordinators highlighted inefficiencies with on-call arrangements and staffing shortages to instigate action to address the over-long hours they worked covering missed visits and on-call emergencies. While these examples affected the smooth running of the service delivery they did not have any detrimental impact on people's experience of the support they received, as no one missed any calls, and shifts were always covered in the supported living houses.

We were told that family and carer meetings had been held for people to be meaningfully involved in how the service was delivered, but attendance had been very low. Staff meetings in the supported living houses were held regularly and those staff that only worked in community were asked for their views in supervision or during 'spot checks' of their performance

Staff practice followed clear guidelines and was consistent with regards to cross-sector working with other organisations. The registered manager worked openly and collaboratively with other agencies and organisations by building good relationships and keeping in contact with their officers and workers, sharing information and listening to and acting on advice when it was offered. This supported care provision, service development and joined-up care for people.

Data protection was appropriately managed and the service was registered with the Information Commissioner's Office. The registered manager was aware of the new data protection legislation recently introduced by the European Union.