PSS (UK)

PSS Shared Lives Norfolk and Suffolk

Inspection report

Unit 14 Diss Business Centre
Dark Lane, Scole
Diss
Norfolk
IP21 4HD

Tel: 01379644423
Website: www.pss.org.uk

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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 Shared Lives Norfolk and Suffolk provides a 'shared lives' service for adults who need support and who want to live as part of a family or household. It is an alternative to residential care for people and provides a flexible form of accommodation, care or support inside or outside the Shared lives carer's home. It provides services for people with learning, physical or sensory disabilities and people with mental health conditions. The service provides long term placements, short term placements and respite care. It is responsible for co-ordination between the people who use the service and the carers with whom people live.

The service worked closely with commissioners, social workers and health professionals who were involved in the care of the people who used the service to ensure their needs were met. The staff directly employed by PSS Shared Lives Norfolk and Suffolk were responsible for recruiting and supporting the self employed carers. These carers provided care and support, in their own homes, to the people who used the service. For the purposes of this report we will refer to those who provide care and support to people who use the service as 'carers'. The support workers from PSS Shared Lives Norfolk and Suffolk, who provide support to these carers and people who use the service, will be referred to as 'staff'.

At the time of this announced comprehensive inspection on 12 December 2018 there were 123 people using the service. Of these, 85 people were receiving personal care, which is regulated by the Care Quality Commission (CQC). We gave the service 48 hours' notice of the inspection visit because we needed to be sure that someone would be available.

The service was registered with CQC in November 2017, this was their first inspection. The service had previously been owned by another provider. PSS Shared Lives Norfolk and Suffolk took over the commissioned care, carers and staff from the previous provider. Many changes had been made within the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There were systems in place designed to provide people with safe care. Risks to people were managed, including risks from abuse and in their daily lives. Recruitment had been carried out to ensure there were enough staff to support carers and people. Carers and staff were recruited safely. Where people required support with their medicines, this was provided safely. The service learned from incidents to improve the service. There were infection control procedures in place to reduce the risks of cross infection.

People were provided with an effective service. Carers and staff were trained and supported to meet the needs of the people using the service. Where people required assistance with their dietary needs, this was provided. People were supported to have access to health professionals where needed. The service worked

with other organisations involved in people's care to provide a consistent service. The service understood the principles of the Mental Capacity Act 2005 and carers and staff were trained in this subject.

People received a caring service. People had positive relationships with their carers and staff. People's dignity, privacy and independence were respected and promoted. The views of people and carers were listened to and valued.

People were provided with a responsive service. People received care and support which was assessed, planned and delivered to meet their individual needs. There were systems to gain people's end of life decisions, policies and procedures guided staff and carers on end of life care. A complaints procedure was in place and the concerns of people and carer were addressed.

People were provided with a service which was well-led. There were systems in place to assess and monitor the service provided. Where improvements were identified actions were taken to address them. As a result, the service continued to improve.

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.

There were systems in place designed to reduce the risks to people from abuse and avoidable harm.

Staff had been recruited to support carers and people who used the service. The recruitment of carers and staff was robust.

There were systems to support people with their medicines, as required.

Infection control processes reduced the risks of cross infection.

Is the service effective?

Good

The service was effective.

Carers and staff were trained to meet the needs of the people who used the service.

The service understood the principles of the Mental Capacity Act 2005.

Where people required support with their dietary needs, this was provided effectively. People were supported to access health professionals, where required. The service worked with other professionals to provide people with a consistent service.

Is the service caring?

Good

The service was caring.

People were treated with care and kindness and their privacy and independence was promoted and respected.

People's choices were respected and listened to.

Is the service responsive?

Good

The service was responsive.

People's individual needs were assessed, planned for and met.

There was a system to manage complaints.

Is the service well-led?

Good

The service was well-led.

The service assessed and monitored the care and support provided to people, to identify where improvements were needed. Actions were taken to improve where required.

PSS Shared Lives Norfolk and Suffolk

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.

This announced comprehensive inspection was carried out by one inspector on 12 December 2018. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that someone would be available.

The inspection activity started on 12 December 2018 and ended 14 December 2018. On the first day we visited the office. We spoke with the registered manager, two coordinators, two shared lives support workers and one team manager. We reviewed three people's care records, records relating to the management of the service, training records and quality and monitoring records. On 13 December 2018 we spoke with two people who used the service and seven carers on the telephone. On 14 December 2018 we spoke with two carers on the telephone.

We reviewed information we held about the service, including the statement of purpose, their registration documents and notifications we received from the service. Notifications are required by law which tells us about important events and incidents and the actions taken by the service. We also reviewed information sent to us from other stakeholders for example the local authority and members of the public.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

For the purposes of this report we will refer to those who provide care and support to people who use the

service as 'carers'. The support workers from PSS Shared Lives Norfolk and Suffolk, who provide support to these carers and people who use the service, will be referred to as 'staff'.

Good

Is the service safe?

Our findings

Carers told us that the service's systems reduced the risks to people and themselves.

The service had systems in place designed to protect people from avoidable harm and abuse. This included training for carers and all staff working in the service. Carers and staff confirmed they had received this training and understood their responsibilities relating to safeguarding. The service had made safeguarding referrals where concerns about people's safety were identified, included when incidents had been reported by carers. This demonstrated that staff working in the service and carers understood when concerns should be reported. Where required, the service had learned from incidents and took action to reduce future risks. This included providing support to people using the service and carers and reviewing their care records and risk assessments.

Risks to people's safety were managed. People's care records included risk assessments which identified how risks were minimised, this included risks associated with mobility, going out in the community, finances, medicines and risks in the home environment. These were reviewed to ensure they were up to date and reflected people's current needs. Risks were also assessed in the carer's own homes, this included the required health and safety checks of the environment, such as gas safety certificates. Carers needed to supply evidence of these checks to the staff of PSS Shared Lives Norfolk and Suffolk before they could provide care in their own homes. One care said, "I had to show that I'd done health and safety checks, gas certificate, electrical, landlords certificate. They [staff] checked all this was done." Carers told us that they attended first aid training.

The registered manager told us about the system to keep staff safe. They showed us records which confirmed what we had been told. The shared lives staff worked alone and there was a lone working policy in place. The staff were required to add their name and whereabouts on a white board in the office. They were required to call into the staff on duty after each visit to confirm their safety. If visits were after 5pm there was a duty team at the head office for support and also for staff to call to confirm their safety. Staff were expected to inform the duty team of the expected time of finishing and a time they would call in by. If this was not done the police were called if they could not be located. There was a lone worker profile for each shared lives staff with, for example, their car registration and description. One staff member told us that the registered manager had been supportive when they had not felt safe undertaking a carer visit in a remote area in the dark.

The service had taken on the staff from the previous provider. However, some of these had left, leaving the service short of shared lives staff. To reduce the risks of the carers and people not having enough support the provider had taken the decision to employ two agency staff. These staff had applied for full time posts and were starting in January 2019. In addition, another shared lives staff member had been employed. Carers told us that their allocated staff member was available when needed. One carer said, "They are always there when I need them, if I phone they get straight back to me. There is a quick turnaround if I need support."

Staff spoken with confirmed that recruitment checks had been undertaken before they could start work. These checks were designed to ensure that they were of good character and suitable to work in the service.

We reviewed the systems of recruitment by looking at records and discussions with the registered manager. Staff working in the service and carers were required to supply a full work history, references and evidence of a satisfactory Disclosure and Barring Service (DBS) check. Records showed that carers were required to update their DBS three yearly and these were maintained on the service's computerised system, which alerted staff when they needed to be reviewed. As part of the carer recruitment, they were provided with a carer pack which included guidance including an overview of shared lived, health and safety, safeguarding, good practice, the statement of purpose, accidents and incidents, hygiene and infection control. Carers were expected to undertake training and provide health and safety evidence of their home, in addition they were assessed by an external panel for their suitability of a shared lives carer.

There were systems to provide people with the support they required with their medicines safely, where support was needed. People's care records identified the support they required with their medicines, and the medicines prescribed. Carers supported people with their medicines. The safety of medicines were reviewed by members of the shared lives staff. This included medicines competencies, such as checking records were maintained appropriately. Staff and carers had received training in medicines administration and their competency was assessed by the management team.

Staff and carers received training in infection control and food hygiene. There were policies and procedures which guided staff and carers on how the reduce the risks associated with cross infection.

Good

Is the service effective?

Our findings

People's care needs were assessed holistically. This included their physical, mental and social needs and protected characteristics relating to equality. Prior to people starting to use the service, a needs assessment was carried out, in consultation with the person and their relatives and/or allocated worker, where required. This information was used to form people's care plans and to match carers with people, including carers who had the skills and attributes to care and support to the person effectively. One carer told us that this process had worked well and the person who they cared for and supported had been, "Well matched to us." Carers were provided with a 'pen picture' of a person and if they felt they could meet their needs, and the person using the service agreed, meetings were held. This ranged from meeting for a drink in the community, visits to the carer's home and overnight visits. If people using the service and carers felt that they could work together the placement went ahead. This provided a smooth transition for people and carers, with ongoing support provided by staff.

The service had systems to provide carers and staff with the training they needed to meet the needs of people and undertake their role effectively. We reviewed training records which showed that staff and carers received training in subjects including moving and handling, safeguarding, medicines, infection control, challenging behaviour, Mental Capacity Act 2005 and equality, diversity and human rights. Carers were expected to undertake, what the provider called 'essential training,' before they could care for and support people. In addition, there were further training courses available which related to the specific needs of people including diabetes and epilepsy. One carer said that the person who used the service that lived with them had complex health needs and the service had provided training the person's specific needs. The registered manager told us that the training provision had been updated to e-learning and carers were provided with access to this and checks were undertaken on the completion of the 'essential training'. Where carers had difficulties using the e-learning system the staff could provide support. This was confirmed by a carer who told us, "We have asked for the training to be given to us on paper and this is being sent." In addition to the e-learning there was face to face training available such as first aid.

Staff were provided with the opportunity to achieve recognised qualifications relevant to their role. New staff were provided with an induction which included training and working with colleagues. Staff, if they had not achieved a qualification, were supported to complete or work on some modules of the Care Certificate, which is an industry recognised set of induction standards. The training records were in transition of being put onto a new computerised system. The registered manager told us that this needed some readjustment to ensure that all of the staff who needed it could access the records. An appointment was booked with a staff member from the head office to visit the service to remedy this the week after our inspection. However, from the two sets of records we reviewed we could see that training was completed, as required. Where updates were needed this was identified.

Records showed that staff received one to one supervision meetings. Supervisions provided staff with the opportunity to discuss their work, receive feedback on their practice and identify any further training needs they had. The staff we spoke with told us that they felt supported by colleagues and the registered manager. Carers were supported by the shared lives support staff. Carers told us that they felt supported by the shared

lives staff and that when they needed support this was provided promptly.

The service worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. This included commissioners, allocated workers, such as social workers and health care staff. We received feedback from a commissioner who told us that the service worked well with them.

People were supported to maintain good health and had access to health professionals, where required. Where care workers and/or staff had identified concerns about people's wellbeing, with people's consent, health care professionals were contacted to arrange for appointments, if people were not able to do this themselves. In addition, the registered manager shared examples with us of where they had spoken with health care professional regarding people's health and wellbeing to ensure that people received a consistent service.

Some people required support to maintain a healthy diet. Records demonstrated that people were provided with the support they needed in this area by carers. This included advice and support on healthy eating and where people had stated that they wanted to lose weight. Where required, carers accessed the support of dieticians or Speech and Language Therapists (SALT).

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

People's care records included information about if people had capacity to make their own decisions. Records showed that people using the service had consented to the care they were being provided with, where they were unable to consent, this was documented and the carer or another responsible person such as their allocated worker or family member had consented on their behalf in their best interests. Staff and carers received training in the MCA. Staff undertook capacity assessments and the registered manager told us of examples of when best interest decisions had been made to ensure that people were safe.

Good

Is the service caring?

Our findings

The staff spoken with, including the registered manager were passionate in providing a caring service and talked about people in a compassionate manner. Carers we spoke with spoke about the people they cared for and supported in a caring way. They clearly knew the people using the service well. One person who used the service told us how they felt cared for and respected by their carer. Carers told us that they felt that the staff were respectful. One carer said, "I can't fault them at all." Another carer said, "They have been really supportive and what is good is that [allocated staff] has taken time to know [person using the service]."

The service provided support to carers and people who used the service. There was a plan to meet with carers and people who used the service every eight weeks. Due to the previous constraints on staffing this was being done on a 10 to 12 week basis. Once the new staff had started in January 2019 the support contact would be more frequent. The registered manager told us, previously carers were supported but there had been little contact with people who used the service, who were central to the service's business. This had been identified as an area which needed improvement and had been addressed. Staff told us this was a positive move forward and that in order to support carers effectively they also needed to know the person. Carers also commented on how the support for them and the people who used the service had increased, which they saw as positive. One carer said, "Contact has increased, it is nice to have this to offload if I need to."

People who used the service were spoken with by the staff to check that they were happy with their placements and if anything was needed. They did this, as much as possible, to respect their privacy without their carer present. This included visiting people at their college or day service, if required. One carer told us that the staff, "Checked with [person using the service] if they are okay. I come out of the room so they can have some privacy and talk freely."

Records were stored securely in the service, which reduced the risks of the personal information of staff, people using the service and carers being accessed.

People's care records included guidance on how their rights to privacy, dignity and respect were promoted. People's care plans identified the areas of their care that they could attend to independently and how this should be promoted and respected. Carers told us how they supported people with their independence, where required. This was in areas such as with their personal care, accessing the community and with their finances. People's care plans identified their goals for independence and how they were supported to achieve these.

Staff listened to what people who used the service and carers said and their views were valued. People's care records were written in a person centred way and people had discussed what they wanted in their care plan. This included their goals for the future and how they wanted to be cared for.

People who used the service and carers were provided with information about advocacy services in the areas they lived in. This allowed them to access advocates, where required.

Good

Is the service responsive?

Our findings

One person told us about the care and support they received, "I am very happy, fantastic." People's care records identified how their person centred needs were assessed, planned for and delivered. People's specific needs were identified in the care plans and how these affected them in their daily living and relating to the care provided. The records gave a picture of the person, what they liked and disliked, what was important to them and how they wanted to be cared for. The records were clear and easy to follow. Reviews on people's care were undertaken to ensure people received care that reflected their current needs. This included visits and telephone calls to carers and people using the service by staff and a formal annual review. One carer said, "Our annual review is up to date." Carers told us that they felt that the service and their allocated staff member were supportive and were accessible if they ever needed any advice or just to talk.

Carers provided a range of support to people. There were long term placements where people lived in the carers family home for as long as they wanted or needed to. One carer told us how they had cared for one person for many years and they felt that the person's needs were met appropriately. Respite care included short term care from the person who used the services' usual home, which could be their own family home or a long term shared lives placement. Short term could range from day care or shorter periods of care. The registered manager told us about examples of how this worked, such as a person no longer attended their day centre and had agreed to have support from a carer on days throughout the week. The person did activities of their choice during this time. This demonstrated that the service had systems to respond to people's specific needs and choices.

Carers told us that if they had any problems or issues they needed to discuss, the staff quickly responded to them and provided assistance where needed. The registered manager told us that this could range from signposting carers to other professionals regarding benefits to arranging respite care for people who used the service.

People and carers were provided with information about how they could complain about the service provided. Discussions with the registered manager and records demonstrated that complaints and concerns were taken seriously, investigated and responded to. Where required, complaints were used to drive improvement. This included visiting the complainant to seek a resolution. We had been made aware of a concern raised, documents and discussions with the registered manager identified that this was responded to appropriately, including guidance sought from the provider's senior team.

The registered manager told us that an area for improvement had been identified that they and the staff had not always recorded compliments received. A system had been set up to do this and we could see that compliments were now being recorded when received.

The registered manager told us that there were no people using the service who required end of life care. However, they would provide this service if required. There were policies and procedures for end of life care and documentation available to be completed if people wanted to make decisions about their end of life

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Good

Is the service well-led?

Our findings

This service was registered in November 2017 and was their first inspection. The service had been previously registered under another provider. This service had taken on the commissioned work from Norfolk and Suffolk County Councils, carers and staff. We reviewed the service's registration documents which identified that the registered manager understood their roles and responsibilities in providing a good quality service.

Since the new provider had taken over the service, they had assessed and monitored the care provided and systems in place. They had developed an action plan which identified the improvements to be made and timescales for the implementation. When improvements had been addressed this was included in the action plan. The registered manager told us that they had not yet fully met all the actions on their action plan, such as the full staffing levels. We were assured that there were systems in place to provide people using the service and carers with a good quality service.

The Provider Information Return (PIR) identified what the service did well and the improvements they intended to make. This demonstrated that the management team and provider understood their roles and responsibilities and continued to improve the service provided to people. We received feedback from a commissioner to the service which confirmed the improvements the service were making and how they kept them updated.

The registered manager was supported by a team of staff, including coordinators, shared lives staff and a team manager. Their roles included organising visits and support to people and carers, assessing people's needs, completing care plans, monitoring daily records, finances and human resources. This assisted the management team in assessing and monitoring the service provided. The registered manager told us that they felt supported by the provider's senior team. Support and advice was provided when needed. Information relating to the service provided, including incidents and safeguarding were inputted onto the computerised system and these were monitored by the provider's senior team. Incidents and safeguarding were analysed and learning actions taken to reduce future risks was recorded by the registered manager. The provider analysed safeguarding incidents and these were checked for any patterns and a report was completed on all safeguarding.

The provider's quality team undertook checks and audits in the service. An action plan was developed to show how improvements were to be implemented. This was kept under review and the action plan and improvements made were monitored. Manager workshops were held every three months, which were attended by registered managers, members of the provider's senior team and the quality team. These provided registered managers with a forum to discuss best practice, patterns and trends arising in the service's and any concerns arising.

There was an open culture, people using the service, carers and staff were asked for their views and these were listened to and valued. Satisfaction questionnaires were sent out to gain individual's views of the service. These were analysed and action taken as a result of comments received to improve the service. 'You said, we did' information was provided on the actions that had been taken as a result of comments received.

People and carers had also provided their comments about the service provided during their reviews and support visits and calls from staff. Carers told us that they had seen a lot of changes in the service since the new provider had taken over. They felt supported and any concerns or comments they made were addressed.

Staff were regularly supervised, including the registered manager. Following a supervision meeting an action plan was completed to identify actions for ongoing improvement and development. Staff told us that they felt supported by the registered manager. One staff member had shared an example of how they had asked the registered manager to provide a map of Norfolk and Suffolk to assist them with identifying where carers were based and any gaps in areas which needed targeting, this was provided. Staff meetings were being held of site to ensure that they could focus on discussions regarding any improvements needed or issues arising. The registered manager told about the work they were doing to assist staff to develop in their role, including asking staff to chair team meetings. A staff team building day had been arranged for January 2018.

There were policies and procedures in place which gave guidance for staff and carers to meet people's needs, these were reviewed by external auditors. The registered manager told us that when policies and procedures had been reviewed and updated staff were required to read them, the computerised system recorded when these had been read.

The registered manager told us about the positive relationships they maintained with other professionals. This included those who commissioned the service and other professionals involved in people's care. The registered manager told us, which was confirmed by a commissioner and records, showed that regular meetings and reports to commissioners were regularly undertaken. This kept them updated on improvements being made on the service's action plan and the information required relating to the service they commissioned about the carers and people using the service.