London Borough of Hackney

Supported Living Schemes

Inspection report

Hackney Service Centre
1 Hillman Street, Hackney
London
E8 1DY

Tel: 02083564864
Website: www.hackney.gov.uk

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 23, 24, 25 and 26 February 2016 and was announced. The provider was given 48 hours' notice because we wanted to be sure there would be someone at the office when we called. We told the registered managers we would visit some of the schemes over the next few days. At our previous inspection on 3 October 2013 we found the provider was meeting the regulations we inspected.

Supported Living Schemes (also known as Housing with Care) provides personal care and support to people living within supported housing. At the time of our visit the service was providing support to 270 people in 15 schemes across the London Borough of Hackney. All of the people using the service were funded by the local authority.

There were two registered managers in post at the time of our inspection. 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.

One of the registered managers was responsible for eight schemes, the other for seven schemes. There were10 scheme managers covering the 15 schemes, who each reported to one of the registered managers.

People and their relatives told us they felt safe using the service and care workers had a good understanding of how to protect people from abuse. Staff were confident that any concerns would be investigated and dealt with. All staff had received training in safeguarding adults from abuse and had a good understanding of how to identify and report any concerns. Scheme managers were notified when training was due to expire and requested refresher training for care workers.

People's risks were managed and care plans contained appropriate risk assessments which were updated regularly when people's needs changed. Care workers worked with all people across individual schemes to ensure they were aware of the needs of each person. The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service.

People who required support with their medicines received them safely and all staff had completed in-depth training in the safe handling and administration of medicines, which was refreshed every three years. However not all schemes had a recording system in place for the disposal of medicines.

Care workers received an induction training programme to support them in meeting people's needs effectively and were always introduced to people when they started work at the scheme. They shadowed more experienced staff before they started to deliver personal care independently and received regular supervision from management. They told us they felt supported and were happy with the supervision they received.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). Care workers respected people's decisions and gained people's consent before they provided personal care.

Care workers were aware of people's dietary needs and food preferences. Care workers told us they notified the team leaders or scheme managers if they had any concerns about people's health and we saw evidence of this in people's care plans. We also saw people were supported to maintain their health and well-being through access to health and social care professionals, such as GPs, occupational therapists and district nurses.

People and their relatives told us care workers were compassionate and caring and knew how to provide the care and support they required. Care workers understood the importance of getting to know the people they supported and showed concerns for people's health and welfare.

People told us that staff respected their privacy and dignity and promoted their independence. There was evidence that cultural requirements were considered when carrying out the assessments and making sure these needs were met.

People were involved in planning how they were cared for and supported. An initial assessment was completed from which care plans and risk assessments were developed. Care was personalised to meet people's individual needs and was reviewed if there were any significant changes, with health and social care professionals being contacted to authorise changes in care received. People and their relatives were actively encouraged to express their views and were involved in making decisions about their care and whether any changes could be made to it.

People were supported to follow their interests, take part in social activities and maintain relationships with relatives and friends that mattered to them.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. There were also surveys in place to allow people and their relatives the opportunity to feedback about the care and treatment they received.

The service promoted an open and honest culture and the registered managers were transparent in their discussions with us. Staff spoke highly of their teams and felt well supported by their scheme managers and team leaders. Staff were confident they could raise any concerns or issues, knowing they would be listened to and acted on.

The registered managers had a good understanding about the importance of links with community services and other organisations involved in adult social care.

There were effective quality assurance systems in place. The registered managers followed a monthly and annual cycle of quality assurance activities and learning took place from the result of the audits. They were aware of their Care Quality Commission (CQC) requirements in relation to notifying us about incidents that happened within their schemes.

We made one recommendation in relation to medicines records.

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

Not all aspects of the service were safe.

Medicines were administered and recorded by staff who had received relevant medicines training which was refreshed however not all schemes had a recording system in place for the disposal of medicines.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm.

Risk assessments were in place to identify the areas of risk and to reduce the likelihood of people coming to harm.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and there were sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff understood the legal requirements of the Mental Capacity Act 2005 (MCA) in relation to consent to care and treatment.

People received care and support that met their needs and reflected their individual choices and preferences. Care workers received the training and support they needed to meet people's needs and were passionate about their job.

People were supported to maintain a healthy balanced diet which took into account their likes and dislikes, as well as cultural and medical needs.

Staff were aware of people's health and well-being and responded if their needs changed. People had access to health and social care professionals, such as GPs, occupational therapists and district nurses.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were happy with the care and support they received. Care workers knew the people they worked with and they were treated with courtesy and respect.

People, including relatives and health and social care professionals, were informed about their health and well-being and were actively involved in decisions about their care and support, in accordance with people's own wishes.

Care workers promoted people's independence, respected their dignity and maintained their privacy.

Is the service responsive?

Good

The service was responsive.

Care records were personalised to meet people's individual needs and care workers knew how people liked to be supported. The information was detailed, easily accessible for staff and updated if there were any significant changes.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The service gave people and relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Good

The service was well-led.

People and their relatives told us that the service was well managed and the registered manager and scheme managers were very kind and approachable. Staff spoke highly of them and felt they were supported to carry out their responsibilities.

The provider was aware of the CQC registration requirements regarding the submission of notifications about serious incidents and followed them up with health and social care professionals.

There were regular audits and meetings to monitor the quality of the service and identify any concerns. Any concerns identified were documented and acted upon.

Supported Living Schemes

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.

The inspection took place on the 23, 24, 25 and 26 February 2016 and the first day of the inspection was announced. The provider was given 48 hours' notice because we wanted to make sure there would be somebody available when we called. We told the registered managers that we would be visiting some of the supported living schemes over the next few days.

The inspection team consisted of two inspectors over four days. One inspector was present for all four days while the other inspector was present on day one and day three of the inspection. Before the inspection was carried out we reviewed the information the Care Quality Commission (CQC) held about the service and statutory notifications received by the provider. This included the report for the last inspection that took place on 3 October 2013, which showed the service was meeting all the regulations that we checked during the inspection.

We spoke with 20 people using the service, six relatives and 32 staff members including two registered managers, one locality manager, four scheme managers, five team leaders and 20 care workers. We also observed interaction between staff and people using the service. We looked at 15 people's care plans, 19 staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Following the inspection we spoke with four health and social care professionals who had worked with people using the service for their views.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe when they were receiving care. One person said, "I do feel safe here, they give me great support." Another person said, "I'm being well looked after, I don't have to worry about security, they look after me here." One relative told us they thought their family member was safe and said, "They carry out regular checks and do all they can to help [my family member]. We can't fault that."

In the schemes we visited people appeared to be comfortable and relaxed in the staffs' presence. Staff had a good understanding of safeguarding procedures and were able to demonstrate how to keep people safe from the risk of abuse. They were able to explain in detail the signs of abuse and what actions they would take if they thought somebody was at risk. They were aware of the provider's whistleblowing policy and knew they could contact other organisations if they had concerns. One care worker said, "If I did have any concerns, I'd report it to the team leader or the manager and raise the safeguarding alert. I know I could go above them if I needed to." This topic was covered during the staff induction and discussed during regular supervision sessions. The training records we looked at showed that staff received regular safeguarding training and scheme managers were notified when it was due to be refreshed. All of the schemes we visited had safeguarding posters displayed throughout the building and the safeguarding adults policy was made available to all staff.

There were procedures in place to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs was carried out by the provider and the housing association. This was to initially assess their suitability to live in the schemes and to identify any potential risks to providing their care and support. Some of the risk factors that were assessed related to people's daily routine, mobility, medicines, eating and drinking, level of cognition and physical health and well-being.

This information was then used to produce a detailed care plan and risk assessments around the person's health needs. The care plan and risk assessment contained details about the level of support that was required and detailed information about any health conditions and the best outcomes or goals for the person. The information in these documents included practical guidance for care workers in how to manage risks to people. It also included a moving and handling risk assessment focussing on the individual, the potential risk to the care worker and the task to be performed. Care workers knew about individual risks to people's health and well-being and how these were to be managed. Records confirmed that care was planned to take into account and minimise risk. For example, one person had been assessed for potential risks after they returned from hospital after having medical treatment at hospital. The care plan gave instructions to staff to check on the person at regular intervals and ensure they had enough food and drink. It was also recorded to encourage the person to use the alarm bell if they weren't feeling well. We saw the arrangements for the medical treatment within the care records and also observed the morning handover between staff where routine checks were discussed once they returned home. Care plans and risk assessments were updated every six months or sooner if there were any significant changes to a person's needs.

We found that staffing levels at the schemes we visited were sufficient to meet people's needs. In one of the schemes, which was a 24 hour scheme, we spoke with the scheme manager about staffing levels. The scheme had the capacity to support 41 people and at the time of our inspection there were 38 people using the service. There were eight staff in the morning and seven in the afternoon to evening, with two staff working overnight. The scheme currently had six vacant posts and they were using agency staff while the positions were being recruited to. The scheme manager said, "We try to retain regular agency staff to provide consistent support for people. We also encourage agency staff to apply for the permanent positions." The registered manager told us they were currently restructuring the service and were using agency staff to cover the additional hours. We saw a copy of an agency staff request form which worked out how many staff hours were required for that specific scheme.

The staff files that we looked at showed that the provider had robust recruitment procedures in place to help safeguard people. We saw evidence of criminal records checks and photographic proof of identity. In one scheme, the manager showed us all Disclosure and Barring Service (DBS) records for staff which were all in date. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services.The provider asked for two references and people couldn't start work until they had been received. One section within the reference request forms gave the opportunity for the previous employer to rate the candidate, from a scale of one to five, in a number of areas around attitude and performance. Areas included honesty and integrity, attitude to seniors and quality of work. Of the references we saw there were no negative ratings and some staff had received a maximum rating in all areas. We also saw records which included feedback from people's interview, which covered areas in assessing risk, best practice in carrying out personal care and person centred planning. The registered manager showed us a copy of a panel interview assessment form where candidates had been assessed as to whether they met the criteria for the role they had applied for. Those who didn't meet the criteria weren't successfully recruited.

Some people were supported with their medicines as part of the overall care package they received. Care plans contained information about people's medicines. This included how the person's medicines were administered, when they were supposed to take their medicines and whether people self-administered their medicines. One of the scheme managers told us that they had a two way process regarding medicines. Some people required prompting and support from staff and others had taken responsibility to self-administer as part of their care plan to promote their independence. This demonstrated that the provider took into account people's independence in relation to medicines and provided the appropriate level of support. We checked how the medicines were received, stored and administered and could see there were safe systems in place. Staff signed for medicines when they were delivered and it was the responsibility of all staff on duty to ensure that people got their medicines at the right time and in the right way. One relative said, "I know he receives his medication at specific times as I have been there on occasions and it is always recorded in a log book that is kept in his flat and is available to read."

We looked at a sample of medicine administration record (MAR) sheets across three of the schemes we visited and saw they were appropriately completed and checked on a regular basis for any errors. Any errors that were found were recorded and discussed with the team leader and care worker. One care worker at one of the schemes told us they had been assigned as the 'medication officer' and would check MAR sheets on a daily basis. They said, "I check the MAR sheets every day. If I see any issues I speak with the manager, speak with the staff involved and it would be actioned by the end of the day." There was an identifier signature form available in one the schemes so staff would know who had administered people's medicines.

We also looked at how people received PRN medicines. This is an abbreviation of 'Pro Re Nata' and is commonly used on medicine administration charts to indicate that a medicine should only be given 'as

needed'. We saw one example where a PRN medicine was administered and logged in the contact book and MAR sheet, however it was not recorded why it was given. We spoke with one of the team leaders about this and it was immediately addressed at a handover meeting with all staff present. One of the schemes did not have a recording system in place for the disposal of medicines. The team leader explained they had requested this from the pharmacy and agreed to contact the pharmacy to rectify this.

We recommend that the provider seeks advice from a reputable source about the safe disposal of medicines across all of their schemes.

Good

Is the service effective?

Our findings

People told us they were happy with their care workers and felt they had the skills and experience to meet their needs. Comments included, "My care worker, she's good and extremely efficient with how she helps me. I'm very happy here" and "I get really good support here, they help me with all that I need." One relative told us they were very happy with the staff that cared for their family member and felt they were very knowledgeable across the board. Another relative said, "He couldn't be better looked after, everything they have done has been incredible."

When people started their employment with the service they attended a corporate induction day at the head office where they met members of the management team and had an introduction into the organisations key policies and procedures. The Care Certificate formed the main part of the induction programme which was a five day course of classroom based learning. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. The registered managers told us it took approximately 12 weeks to complete and staff would have their induction signed off. New starters confirmed this and we saw records within individual staff files. One care worker said, "The induction was wonderful. The training was very in depth and I had great support from the staff team."

The training that was delivered to staff as part of the induction included safeguarding, moving and handling, health and safety, medicine administration and infection control and was refreshed on a regular basis. A team leader at one of the schemes showed us their staff training matrix which identified when training had been completed and when it was due to be updated. They added that they were notified by head office when training was due to be refreshed and we saw records requesting for care workers to attend training sessions. Staff also received training which was specific to people's individual needs and we saw care workers had completed training in a range of areas, including the Mental Capacity Act 2005 (MCA), dementia awareness, Deprivation of Liberty Safeguards (DoLS) and continence care. One care worker said, "The training is very useful, enlightening and I have learnt a lot from it. Another care worker told us they found the dementia awareness training a real eye opener. They added, "I learnt a lot from it, especially understanding the symptoms, the behaviours and how to manage it."

We saw records that showed care workers had regular supervision every three months and an annual appraisal system was in place. We looked at records of supervision sessions which showed care workers were able to discuss key areas of their employment. Items discussed included safeguarding, training development, promoting people's health and well-being and any recent issues involving people they supported. It also focused on working in line with the Care Quality Commission (CQC) standards. One care worker told us they were happy with their input during supervision sessions and it was a good opportunity to discuss everything about their work. "I get to talk about my development, the challenges we face and they listen to my views and act upon them."

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to

do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We discussed the requirements of the MCA with the registered managers and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records in care plans that showed best interests meetings had taken place and when mental capacity assessments had been completed. In one care plan a financial assessment had been undertaken and highlighted a deputy had been appointed to manage the financial affairs of that person.

Staff told us they always asked for people's consent prior to providing personal care for them. They told us that people sometimes needed encouragement when having personal care needs met. One person said, "They always ask me for permission before carrying out their work." One care worker said, "I always explain to them what I'm doing. I give them enough time to understand everything." Where appropriate, the views of people's relatives were sought when assessing risk and developing care plans. One relative said "I speak to them all the time and I've always been involved with the care planning." Throughout the schemes we visited we saw people's care records and consent forms had been signed by people to say they agreed to the care package being delivered however some hadn't been signed. We saw one medicines consent form and a financial assessment consent form that had not been signed.

People required support with meal preparation and in some cases, support whilst eating. People's dietary preferences, allergies, medical and cultural needs were recorded in their care plans along with the level of staff support needed. We looked at a sample of daily log sheets which confirmed people were eating the food that they wanted to. This showed that care workers had read and understood the care plan and were aware of the specific dietary requirements of the people they supported. We also observed team handovers where care workers discussed people's nutrition and hydration and whether there were any current concerns that staff should be aware of. One person who had been assessed as being at risk of choking was advised by health care professionals, such as a speech and language therapist (SALT) and dietitian, to have a pureed diet. However, this person had refused as they enjoyed eating Caribbean food. We saw evidence where staff had requested a best interests meeting with the person and health care professionals. The outcome of the meeting indicated the person would be supported by staff to cut their food up into small pieces and supervised while they were eating so they could continue to enjoy their preferred food. Across the schemes people told us they were happy with the support they received and were able to request foods they liked. One person told us how they were supported to buy food from a Jewish store in line with their religious and cultural needs. A team leader from one of the schemes we visited told us that they would have regular food events, including a fish and chip supper once a week which people and their relatives told us was very popular.

Care workers said they supported people to manage their health and well-being and would always speak with the scheme manager or team leader if they had any concerns about the person's healthcare needs during a shift. The registered managers told us about a service called 'Paradoc', a GP service for people living in Hackney. It is designed to try to keep people at home after an assessment and reduce the number of hospital admissions. We saw posters in the scheme offices and staff were aware of when it was best to call them rather than 999. Team leaders and care workers helped to support people to attend appointments or made referrals to health care professionals. For example, during one morning handover we observed a care worker discussing possible healthcare concerns for a person living in the service. It was agreed for staff to monitor them in the morning and if they had not improved they would request a home visit from their GP. We saw information in people's care records where staff had made contact with a number of health and social care professionals, including GPs, occupational therapists, speech and language therapists and

district nurses. One person said, "They support me with my appointments and sort everything out for me, it's very helpful." Relatives told us that the staff were aware of people's healthcare needs and were always kept updated of the outcome. One relative told us how one of the schemes supported their [family member] with a number of healthcare appointments. "They are usually taken by one of the senior members of staff and I'm always updated as to when they are going and after they've been."

Good

Is the service caring?

Our findings

People had positive things to say about the caring attitude of staff that supported them. Comments included, "If it wasn't for this place I wouldn't be here. I'm very well looked after here" and "Everything they do for me, they do with such courtesy. I'm very, very happy here." One relative told us they were very happy with the staff and how their family member was treated. They added, "She is very caring and my [family member] is very fond of her. I think they know [my family member] better than me in some ways!" Another relative said, "The whole care team treat him with a great amount of respect. He looks forward to getting up in the morning. It's such a relief he is looked after so well."

People were designated care workers to support them with their personal care and day to day needs and they were rotated around people in all schemes. One of the registered managers told us that it was important that staff got to know everybody living in the scheme so there was no permanent allocation of people with care workers. Care workers knew the people they were working with and were able to give detailed information about personal histories. We asked one care worker to tell us about a person who had recently moved into the scheme. They were able to give an overview of the person, had an understanding of their care needs and what activities they were interested in. They added, "Even though I haven't worked with her directly yet, it is important to get to know people and find out how we can support them." Another care worker said, "Everybody here has their own needs, their past, their history and culture. If I can make them happy and make them feel good about themselves then I've done my job."

During a visit to one scheme, we saw a person walking around the home carrying a doll. The staff told us that the doll was an integral part of the person's life and cared for the doll as they would their own child. The doll was an important part of this person's day to day life as they were living with dementia and staff understood why. At another scheme, we observed interactions between people and staff who were preparing for a staff members farewell party in the communal area. We observed that the staff were very approachable, professional and gentle when speaking with people. There appeared to be a calming community atmosphere where people knew each other and were comfortable being with one another. At another scheme we visited, there were pictures of people up on the walls that had been taken during activities and parties. The team leader for the scheme said it was nice to have people's pictures up as this was their home and helped them to remember happy times.

During a handover meeting at one scheme, staff were informed that a person had fallen from their chair within their flat. The team leader immediately went to check on them while an ambulance was called. The person was made as comfortable as possible by the staff member who placed cushions around her back to support her until the emergency services arrived. Staff stayed with the person and reassured them throughout the incident. This showed care workers showed concern for people in a caring manner and responded to their needs in a timely way.

The people using the service and relatives we spoke with confirmed they were involved in making decisions about their care and were able to ask care workers for what they wanted. The registered managers told us when they carried out assessments and reviews they always made sure, where appropriate, a relative was

present with the person. They added that people were assessed for a specific number of support hours per week, the maximum being 21 hours. If they did not think this was suitable they would speak with health and social care professionals to authorise extra hours of support. Once the assessment had been completed and the person was aware of how much support they were entitled to, they would listen to people's preferences and find out how they wanted their care to be carried out. One relative told us that their family member had requested that they didn't want staff coming to check on them at night as it would wake them up. They added, "This was put into place immediately on his request and has been in place for quite a few years now."

The registered managers told us that people were supported to access advocacy services if they needed to. They were able to offer advocacy services that were available through the local authority but also supported them to access external advocacy services. We saw evidence in some people's care plans that they received support from advocates in making decisions about their care. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. One person told us that they used a local advocacy service and also volunteered with them when they could.

People told us staff respected their privacy and dignity. We heard positive comments about how respectful care workers were when they worked with people and how people were encouraged to be as independent as possible. One relative said, "There is in built courtesy. They always try hard to make people feel comfortable." One person told us that staff always knocked on the door before entering. We observed staff knocking on people's doors and announcing their presence during our visits throughout the schemes. At one scheme, a person had fallen asleep in the communal area. The staff member noticed this and made sure they were suitably covered with a blanket. Care workers had a good understanding of the need to ensure they respected people's privacy and dignity. One care worker told us that it was very important to promote people's independence but also make sure they were comfortable with the tasks they were carrying out. We saw evidence in care plans that people had a personal care overview, highlighting their preferences. It was recorded that privacy was to be respected and people were supported to be independent at all times. The registered manager told us that they had 'dignity champions', who were responsible for making sure the scheme was delivering a dignified service. We spoke with one of the care workers who was the dignity champion for her scheme who told us how important it was to treat people with dignity all the time and gave examples of good practice.

Good

Is the service responsive?

Our findings

People told us they were happy with their care and support and that they felt involved when decisions were made about their care. Comments included, "They always ask me if I'm happy with everything and I can't complain" and "They don't pressure me with anything and help me to live here on my own. I'm thankful for that." One relative told us that they were always involved in the care planning and could agree to changes to make sure everybody was happy. Another relative said, "I'm always given the opportunity to get involved and help my [family member] with any important decisions that need to be made."

We spoke with the registered managers about the process for accepting new referrals into the supported living schemes. All of the people that received care and support from the provider were funded by the local authority. People either made contact directly to the provider for support or they would work in partnership with hospitals, community mental health teams, drug and alcohol services and social services about providing appropriate support within their schemes. People were assessed for their eligibility for care and if they met the criteria they would be told what possible places would be available. We saw records of people's initial assessments which highlighted their personal details, their current living arrangements, the date they were referred, the person responsible for the assessment and which scheme(s) would be suitable. One health and social care professional who worked within a hospital setting highlighted how impressed they were with the assessment process and that people were listened to when decisions were being made.

The registered managers added that it was important for people to be involved in the process from the beginning and always involved people, their family and relevant health and social care professionals. During the initial assessment people were given the opportunity to visit the scheme before any decisions were made to see if they would feel comfortable there. One person told us that they came to visit before moving in and got to see an empty room and meet with the staff members. One relative said, "It felt right when we walked in during the visit, I felt reassured straight away." Another relative said, "We were very closely involved in his care plan and reviews, including those with his GP."

Once a scheme had been agreed the service would carry out a further assessment to see what people's care needs were. People were funded for up to 21 hours of support per week and if people required more they would contact social services to request additional support. We saw records in people's care plans where they had been assessed as needing more support, mainly due to requiring two care workers to meet personal care needs. We saw communication log records which confirmed this and observed a morning handover where care workers discussed the arrangements for people who required two care workers. Healthcare professionals were included in the care, such as physiotherapists and district nurses. For example, one person had regular visits from the district nurse to help with changing dressings and to reduce the risk of pressure sores developing. The service also worked very closely with the housing association who managed the building where the schemes were based. The housing association was responsible for providing the person with a tenancy agreement and supported them with housing related issues, such as rent arrears, benefits and maintenance issues. We spoke with some of the housing officers at the schemes we visited who told us that they carried out joint assessments to make sure that both services were able to meet people's needs.

Care plans were detailed, well laid out and easy to understand. Each care plan contained a personal information sheet which had details about the person which included information such as the next of kin contact, their GP or other health and social care professionals, medical conditions and special/cultural needs. Care plans also had other relevant information such as a personal history which explained their reason for placement and gave a detailed health overview, including level of cognition, nutritional needs and sleeping patterns. The care plans demonstrated person centred care was the focus of delivery rather than being task led. There was reference to people's wishes and how they wanted their care needs to be met. People also had an individual night care plan which recorded how people would like to be supported during the night. In one person's night plan it was agreed that they wanted to be checked three times over the course of the night. We saw records in the handover report and the daily logs that the person received the number of nightly welfare checks they had requested. Care plans were reviewed and updated every six months or sooner if there were any significant changes in people's needs. In one scheme we saw a person's night plan hadn't been reviewed within the timeframe. We spoke with one of the team leaders who acknowledged this and made plans to update it during the inspection.

The service supported people to follow their interests and maintain relationships. We saw that people led independent lives and were supported to take part in activities of their choosing. We spoke with one of the welfare and activity officers who was visiting one of the schemes during our inspection. They gave us an overview of the activities that were available within the schemes and relied on volunteers and the care workers to help get people involved. Some of the activities offered throughout the schemes were dementia friendly swimming, cinema trips, coffee mornings (including reminiscence sessions), cooking classes, chair based exercise classes and gardening. People using the service were encouraged to access activities across all the schemes. The registered managers told us this helped people to form friendships across different schemes and help decrease social isolation. One person told us about music activities that he was involved in at the scheme he lived in, but also at another scheme. They added, "I like to play the piano, I've got friends there too." A relative told us about music therapy at one scheme. "My [family member] loves his music. When they play his favourite Jamaican music, he recognises the music and I see him respond. It makes us happy." We saw records of activity logs within some schemes which recorded what activities had taken place and who had attended. People were able to give feedback about activities at tenants meetings and discuss what kind of activities they would be interested in, along with being consulted about future activities.

People were also supported with more specific cultural or religious needs. One person was supported to attend an Irish community centre on a weekly basis while it was arranged for another person to have a reverend come to visit them to meet their religious needs. We also saw records within people's care plans that allowed people to enjoy food that met their cultural needs.

People and their relatives said they were happy with the service and would feel comfortable if they had to raise a concern. Comments included, "I've never had any problems at all with them, but I know I could speak to somebody if I did" and "They look after me so well, how could I complain?" There was an accessible complaints procedure in place and staff also supported people to get their feedback. Both registered managers, senior staff and care workers told us that they always asked people and their relatives if they had any issues or concerns with the service. The registered managers said, "We always reiterate to people and their families that we want them to raise concerns if they have any. We empower them to report concerns without having the fear of repercussions." One relative said, "When I had concerns in the past, they listened to my views and acted upon them straight away, I was happy with that."

There had been 15 complaints in the past 12 months and we saw records of when they were received and a brief description of the issue. Formal complaints were investigated by the registered managers and then

went to the assistant director of adult social care if people weren't happy with the initial outcome. We saw evidence that where people had complained, the provider had responded to them in line with their complaints policy. The registered managers told us that they had monthly managers meetings and discussed any current complaints. We saw minutes of the most recent managers meeting which confirmed this and that they discussed complaints to learn and improve the service.

Good

Is the service well-led?

Our findings

At the time of our inspection there were two registered managers in place responsible for the 15 schemes across the London Borough of Hackney. Our records showed they had been formally registered with the Care Quality Commission (CQC) since July and October 2014 respectively. We met them on the first day of the inspection when we visited the head office where the service is registered.

People using the service and their relatives were happy with the way the service was managed. People told us they felt comfortable talking with the scheme managers and that they were approachable. Comments about specific scheme managers included, "She is a lovely lady" and "They are good here, I get on well with them." One relative said, "I speak with [the scheme manager] virtually every time I visit, he's always there, even at weekends." Another relative told us that they felt so reassured that their relative was being well looked after. They added, "They run a great service, I don't know what I'd do without them."

Care workers told us they were well supported by their management team and had positive comments about the management of the service. They said if they had any problems they could speak to the team leaders or scheme managers, even out of hours. One care worker said, "I can't explain the support, all I can say is that I'm so fortunate to get good support. To be honest, it's the best support I've had." Another care worker told us that they really enjoyed working for the service. They added, "We work as a team and we have a great team here. It's really good and we get great support." Care workers felt that the service promoted a very open and honest culture and care workers knew about the whistle-blowing policy. Care workers told us they were kept up to date with changes within the organisation and due to the restructure some care workers hours had been reduced, which had a slight impact on team morale.

The registered managers were aware of their responsibilities in terms of submitting statutory notifications to CQC informing us of any incidents that had taken place within the schemes. They also understood the importance of notifying other bodies about issues where appropriate, such as the local authority and other health and social care professionals. They told us that as they were part of the local authority, they had daily contact with the safeguarding team, case managers and other social care professionals so they were able to communicate effectively between them about people's care needs.

The registered managers understood the importance of creating links with organisations and community services involved in adult social care. They also had a strong link with the registered social landlords (RSL) who were responsible for managing the building and also supporting people using the service. We spoke with staff from two different housing associations that confirmed how important it was to work together to make sure people's needs were met. There were links with community services, such as memory groups for people living with dementia and we saw these advertised around the schemes we visited. They also engaged with training providers regarding The National Minimum Data Set for Social Care (NMDS-SC) which is an online system which collects information on the adult social care workforce in England. It can be used to record information about their workers. They used it to track training records, plan how many workers they need and use it to compare their business to other care providers locally or nationally.

The registered managers had internal auditing and monitoring processes in place to assess and monitor the quality of service provided. The registered managers had monthly meetings which covered areas such as staff supervisions, a review of each scheme, safeguarding issues and complaints. Specific audits of staff training, medicine administration record (MAR) sheets and hospital admissions were completed on a monthly basis and sent to the registered manager. We spoke with one of the locality managers who told us that when they noticed a pattern of medicines recording errors, they started to audit the MAR sheets on a weekly basis at that particular service to reduce errors. They said, "If we have any concerns, we call the care worker and follow up the incident, which could lead to further training and supervision." We saw further evidence that the registered managers made contact with the scheme managers to ask for information relating to medicines administration, supervisions and number of formal complaints made against the scheme.

The provider also carried out two quality assurance checks on a yearly basis. One was an annual quality assurance visit where people were visited to discuss the quality of service they received. People were asked questions in a number of areas relating to the service they received, such as respect, staff timekeeping, access to services and how well the care team communicates with them. We saw samples of completed surveys in peoples care plans which showed that people were happy with the level of care they were receiving however not every care folder we looked at had a completed survey. The provider also carried out an annual postal survey which is mandatory for all local authorities with over 150 people using their services. The survey asks people using services about the services they receive to try to determine the person's opinion of their quality of life. We spoke with people in the performance and improvement department of the provider who told us the mandatory completion date for data validation and submission of the survey results to the Health and Social Care Information Centre (HSCIC) was the 11 May 2016 and they were on course to meet the deadline. They also told us that they had a duty to notify the relevant social care professional, including the registered manager, if they received feedback from people who indicated that they did not feel safe or felt they were at risk. We saw minutes from a residents meeting that highlighted that the surveys should also be handed out to family members if people were unable to complete them on their own.

All accidents and incidents were recorded and kept within each scheme. The scheme manager sent monthly reports to the registered managers to be discussed at team meetings. We saw evidence that when an incident or accident had been recorded, the relevant people had been notified and plans put in place to minimise the risk of it happening again. We saw records of contact between scheme managers and health and social care professionals discussing incidents that had happened and what outcomes were required to meet people's needs.