Support for Living Limited

Support for Living Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

This inspection took place on the 11,12, 14 and 15 December 2017. The visit was announced.

The provider for Support for Living Domiciliary Care Agency is Certitude and is often referred to as either Support for Living Limited or Certitude. During this inspection report we will refer to the provider as Certitude.

Support for Living Domiciliary Care Agency provides personal care to people with learning and physical disabilities and mental health needs living in their own houses and flats in the community and specialist housing.

This service provides care and support to people living in 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of our inspection there were one hundred and six people being offered a service in twenty four supported living schemes across four local authorities.

At the last inspection, the service was rated Good. At this inspection, we found the service had continued to make improvements and had introduced innovative practices and ideas in many aspects of the service to further enhance the experiences of people using it. We have therefore rated the service as Outstanding. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives said that staff were kind, thoughtful and helpful. Staff were enthusiastic and passionate about their work, speaking very positively about people and wanting the best outcomes for them.

It was a strength of the service that staff had been trained in the use of different methods of communication to ensure people were understood. People were well supported to express their views in a variety of ways that were tailored to their individual needs.

The provider had an internal intensive support team and there was good use of speech and language therapist's and other healthcare professionals to support staff to reach the best outcomes for people. Staff were innovative in their use of technology to support people to express their views and to live more independent lives.

Staff supported people to remain healthy both physically and mentally, there was an emphasis on supporting people's emotional well- being. Community health care professionals visited people and staff supported people to attend routine appointments and hospital clinics. When people found hospital visits

difficult staff worked alongside with health professionals to support them to attend.

People had person centred care plans that gave very good background information about them. Often there were photos of childhood and earlier adult life that showed the person in the context of their life. Care plans reflected their wishes and preferences.

Care plans described people's circle of support and informed staff how people wanted their care and support provided. Staff supported people to attend a variety of meaningful activities of their choice. Staff explored new activities with people to widen their life experiences this included trips to see sporting events and holidays abroad. Staff demonstrated they believed in making people's lives as full as possible seeing opportunities rather than the limitations.

People had end of life plans, some of which contained specific information with regard to their end of life care. We saw some excellent work had been undertaken in one service when supporting a person who chose to have their home as their final place of treatment.

The registered manager and the provider Certitude encouraged feedback from people and relatives in a number of ways such as regular listening events, visiting the schemes and sending out questionnaires to ensure people and relatives could give feedback. As such, they were open and approachable. Staff told us they felt a part of an open and empowering culture where they were respected as individuals. We saw that staff's skills and knowledge were recognised and utilised throughout the service and that staff felt valued and part of a wider team. Exceptional staff work was recognised and celebrated.

The registered manager had developed robust systems to ensure that all records were reviewed regularly and to make sure these contained up to date and relevant information about people. People using the service were involved in the quality assurance processes, to ensure their perspectives on quality were taken into account when deciding whether the provider was providing a good enough service for people. The provider's quality assurance team analysed the monthly audits produced by the managers of the individual schemes to ensure there was a consistently high standard of provision of care and support across the service.

The provider shared their aims and values of the service and communicated with people, relatives, and staff through newsletters, blogs, and events. People were encouraged to be part of national debates with regard to learning disability issues and were empowered by the provider to voice their views. The registered manager looked for ways to continually improve the quality of the service and to raise the profile of issues in relation to learning disability by working with other voluntary organisations and campaign groups.

The registered manager supported people and relatives to complain and the provider investigated complaints thoroughly and responded appropriately to the complainants and to address the concerns.

The provider had ensured that there were robust systems in place to support staff and managers to identify and report safeguarding adult concerns. Managers investigated concerns and lessons were learnt and shared within the whole service to help prevent similar mistakes from arising again.

People had person centred risk assessments that identified measures to mitigate the risks of harm. Managers had undertaken positive risk assessments to promote individuals' independence and to give them freedom of movement whenever possible. Managers had fully involved people in drawing up the positive risk assessments. Health and social care professionals had contributed to the plans that were reviewed on a regular basis.

The provider recruited staff on an ongoing basis and undertook recruitment checks to ensure staff were safe to work with people. Most schemes had consistent staff groups who were familiar with people living in these schemes. The provider's bank of care workers were familiar with people and helped to cover any staff absence.

Staff had received training to administer medicines in an appropriate manner and managers undertook checks to ensure medicines records were completed appropriately and people received their medicines as prescribed.

Staff told us they felt well supported and had received a thorough induction prior to commencing their role and had ongoing refresher training. Specialist training had been provided when required and this had included positive behavioural approaches to behaviour that challenged the service.

The registered manager had ensured managers and staff had a thorough understanding of the Mental Capacity Act 2005 and people's care plans described how they made decisions and what support they required to make a decision. The provider had liaised with the local authority when people required Court of Protection decisions with regard to their care and treatment.

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. The provider undertook risk assessments to ensure people's safety and developed plans to mitigate risks to people and others.

The provider had systems in place to analyse and understand when something went wrong to avoid a reoccurrence.

The provider had systems in place for the safe recruitment of staff and there were bank staff to ensure there were enough staff to meet people's needs during permanent staff absences.

The provider had systems in place for the safe administration of medicines.

Is the service effective?

Outstanding

The service was exceptionally effective. The provider undertook very detailed assessments of people's needs. They worked in partnership with people, relatives and professionals to tailor people's care packages to meet their needs.

Staff supported people using innovative methods to support them to access health care, this included the use of technology to familiarise people who were reluctant to visit health settings.

Staff supported and encouraged people to eat a healthy diet and remain hydrated.

The provider worked according to the Mental Capacity Act 2005 to uphold people's legal rights. Staff understood the need to ask for consent before providing care and support to people.

Is the service caring?

Good

The service was caring. People and relatives told us care staff were thoughtful, kind and helpful.

Staff spoke very positively about the people they supported and were passionate about creating new opportunities for people.

Care plans specified clearly how people communicated. The provider had ensured staff received training to enable them to use a variety of innovative techniques to communicate effectively with people to support them to make choices.

Staff had high regards to people's privacy and safety and always ensures these were respected. They always supported people to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People had individualised person centred plans that were developed with their full involvement or that of their relatives. These described in detail how people's needs should be met. The service was responsive to all of people's needs including their social and recreational needs and interests so they led fulfilling and interesting lives.

The staff were aware of people's end of life care and supported them to express their wishes and preferences in this respect. Information about people's end of life care was recorded in their care plans.

Staff and managers supported people and their relatives to make complaints and the provider investigated and responded to complaints in a robust manner.

Is the service well-led?

Outstanding

The service was exceptionally well- led. The provider went above and beyond in sharing a clear vision of the service with staff, people, and relatives and in seeking their participation in operating the service.

The provider included people who use the service in their audits and checks to make sure people's perspectives were taken into account when assessing the quality of the service.

The provider had a variety of ways to capture people's and stakeholder's views and feedback about the service, including holding listening events to engage with people and their relatives. In addition, the provider obtained people's opinions through their yearly reviews and questionnaires.

The provider supported people, relatives, and staff to attend events so they could contribute to debates relevant to the development of learning disability and autism services on a national level.

The provider ensured service sustainability by working with a number of local authorities to develop new projects for people with learning disabilities and autism.	

Support for Living Domiciliary Care Agency

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 11, 12, 14 and 15 December 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a large domiciliary care agency that provides support to people living in supported living schemes and we needed to ask people's permission if we could visit them in their homes as part of the inspection process.

The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of people with learning disabilities and autism who had complex support needs. The expert by experience made phone calls to people and their relatives over two days.

Prior to our visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events that the provider is required to send us by law.

We visited the office on the 11 December 2018 to meet with the registered manager and the office staff. We reviewed nine staff personnel records, audits and policies and procedures. We visited people living in their homes on the 12 and 14 December. We returned to the office on the 15 December to gather further information and discuss our findings with the management team.

During the inspection, we visited four supported living schemes and looked at one person's records from a

fifth scheme. In total, we looked at nine people's care records. This included their care plans, risk assessments, health records, and daily notes. In the supported living schemes we looked at seven staff's supervision records and training records. We spoke with three support staff, one deputy manager, five managers of supported living schemes, the registered manager, and two heads of service, one service manager, one quality improvement partner, and one data performance analyst. We spoke with four people during our visit and observed staff interaction with people in four supported living schemes.

Following the inspection, we spoke with five people who used the service and six people's relatives. We also spoke with representatives from two commissioning bodies and one social care professional.

Good

Is the service safe?

Our findings

People told us they felt safe living in their homes with staff support. Their comments included, "Yes I am safe, I live here" and "Yes very safe to live in", "I feel safe here" and "Absolutely yes." Staff had received safeguarding adults training and demonstrated they could recognise possible signs of abuse and told us what actions they would take if they suspect a person was being abused. Staff confirmed they would take responsibility to ensure the matter was reported and investigated appropriately. One care staff member told us, "I would complete an incident form, write a report, and talk with my manager. If it wasn't dealt with there is a whistleblowing facility and I would raise it there."

When we visited the services, we saw that managers checked incident reports, daily notes, and staff handover logs to ensure all safeguarding incidents had been flagged to them. They had made safeguarding referrals to the local authority and the CQC was notified in a timely manner. The managers had undertaken thorough investigations and had oversight of the process and outcomes. The provider senior management played an active role in ensuring all actions were taken and that lessons learnt were shared throughout the organisation. The managers demonstrated that learning from the safeguarding incidents and near misses had been shared with their senior staff in the services and when appropriate with the staff group. Following our visit a safeguarding referral was made to the local authority and the CQC were notified.

People had risk management plans to keep them safe. Risks that were assessed included those in respect of mobility, moving and handling, behaviour, epilepsy, and communication. Guidance for staff was comprehensive and highlighted what the level of risk to the person was and what actions staff were required to take to minimise the risks. Most risk assessments were updated on a regular basis and in response to changing circumstances. We found one occasion where a person had improved in their mobility and the risk assessment had not been changed to reflect the person now required one staff member to mobilise instead of two. We brought this to the attention of the manager who agreed to update the information to reflect the progress the person had made.

We saw some very good examples of positive risk taking when people were being supported to remain or become more independent. For example, one person had been risk assessed to remain alone in their home on occasions. A specific period was given, and measures to support them to remain safe were in place. This person also spent time out in the local area by themselves each day. Both their risk assessment and their care plan demonstrated how important this was to them and how their quality of life would be affected, should this not occur. The manager had considered what was most important to the person, considered the risk in relation to their safety, and put appropriate measures in place to ensure their freedom of movement whilst mitigating the risk to them.

Some people had behaviours that required detailed risk assessment to keep them safe from harm. These specified what staff support was required to keep people safe. The provider had used both internal and external behavioural teams to support staff to identify what the risks were and how to reduce these to people. One scheme had reduced the amount of staff required to manage one person's behaviour from three staff to one staff member providing one to one support. They had managed this by having detailed

behavioural support plans to help staff understand what the person was trying to communicate. The difficulty to communicate used to cause frustration to the person which resulted in the behaviours that challenged the service. By addressing the triggers, the staff were able to manage the risks to the person and others.

Staff had undertaken risk assessments with the person's involvement where they had the capacity to contribute to them. For example, one person had complex needs and behaviours that required specialist input from health professionals. The manager had worked with the specialists and the person to develop a person centred risk management plan. The plan was completely centred on the person's own thoughts and their agreement to the measures in place. By supporting the person to develop their own risk assessment with the professionals, the manager had ensured that the person would understand and comply with the measures identified.

We received mixed feedback when we asked people and relatives if there were enough staff to meet people's needs. People's comments were all positive and included, "Yeah the staff are reliable" and "Yes there are enough staff." Relatives' opinions were mixed. For instance one relative said, "For my relative's needs yes, my relative's needs are broadly well met" and another said, "Various staff, yes they are fine. When I'm there they have often taken them [other people living at the service] out to the shops." However, one relative said, "No definitely not, they are short staffed. There have been budget cuts" and another relative told us, "In theory there is, however when it's one-to-one then no there's not."

Staff felt there were enough staff and felt well supported by the provider. One staff member commented, "A good mixture of staff with different skills." The provider told us that when there were staff absences or vacancies bank staff were used to cover. The provider told us they had a bank of around one hundred and fifty staff and thought realistically seventy were available to work for the domiciliary care service. We saw that in some services this was occurring and that where possible the same bank staff were used who were familiar with the people they supported. For example, one bank staff had worked a number of regular shifts at a scheme and had supported one person to go abroad on holiday. The person they supported looked forward to them coming onto shift and responded with a smile when the bank staff's name was mentioned. Managers told us they could usually get cover at short notice and that where required they would work a care shift to cover in staff absence. This was confirmed by a relative who told us, "Very nice, she's [manager] more involved than any managers in the past, she takes her turn with the sleep overs."

We saw that in one scheme there had been some staff changes as care staff had been successful at interview for more senior roles and had moved to other schemes. Staff were on duty at the time of our visit and we saw that some shifts on the rotas were covered by bank staff. However, the service was clearly going through a period of staffing changes and this had meant that staffing was not always consistent. We met new staff that the provider had recruited to the service and we saw the provider was actively recruiting for staff members on an ongoing basis and had a bank of staff to cover in emergency. On occasion, staff from other schemes provided support in regular staff's absence. There was also a very limited use of agency staff when necessary. The provider explained that this was minimal, as they preferred to use staff trained by them to ensure a good standard of care.

The provider had safe recruitment processes to help keep people safe. Prospective staff submitted application forms, and then were invited to attend an interview to assess their experience and aptitude to work as care staff. The provider undertook a number of checks. These included proof of identity and address, criminal record checks and the provider obtained three references one of which was from the previous employer to ensure prospective staff were of good character and safe to work with people. The provider ensured people had a right to work in the UK and that visa documents were renewed and up to

date. Criminal record checks were renewed every three years to check staff had not committed any criminal offence whilst employed.

In addition to the formal interview process, we saw that people's care plans stated what attributes staff needed to support individuals. For example, one person's plan read, "Adaptability, safeguarding adult knowledge, ability to monitor and record, first aid, and communication skills." Another person asked staff to have certain personality characteristics that included, "Caring, patient, happy, and friendly, and have shared common interests." Staff also completed a one page profile. The profile described their strengths and interests and this helped to match staff with the right scheme.

One person with complex support needs had been supported to meet prospective staff who would be working with them prior to their interview. They had prepared with staff support a list of questions that they felt were important and these had been added to the formal interview questions. This was so they could be sure the right staff were selected to work at the service and they had some control over who was working with them and felt comfortable with the new staff.

Staff confirmed they received training on medicines management and managers confirmed they observed staff competency in administering medicines to people. One staff described to us they shadowed experienced staff giving medicines for two weeks before they administered medicines. We checked a sample of medicines administration records (MAR) at some of the schemes we visited. We found no errors in recording medicines that were received and in the MAR. We saw that people's MAR contained information for staff about the use of the medicines and a description of what they looked like, dosage and time of day the medicines should be given. As and when needed medicines were administered by staff appropriately and there were clear guidelines for care staff to follow to administer these medicines, that had been signed as correct by the GP. In one scheme, there were controlled drugs. These were stored in an appropriately secured locker and two care staff signed to ensure that the controlled drugs were administered appropriately. Managers undertook monthly audits to ensure staff had administered medicines correctly.

The provider had ensured care staff received infection control and food hygiene training to support them to follow good practice in avoiding cross infection. Staff confirmed they were issued with protective equipment and we saw staff using this appropriately. In the schemes, there were poster reminders in communal bathrooms and kitchens for staff and people to wash their hands effectively. Communal kitchens seen during our visit were well maintained in terms of cleanliness and measures such as using colour coded chopping boards were in place to avoid cross contamination.

Outstanding ☆

Is the service effective?

Our findings

People's needs were assessed by managers when the local authorities made a referral to the service. This was to ensure that the staff would be able to care for and offer the appropriate support to the people. We met a number of younger adults with complex needs who the provider had supported to move into their own purpose built accommodation. Staff supported people to move and settle into more independent living with their needs carefully identified and the necessary support in place. The commissioning body confirmed that the provider had undertaken the necessary assessments and planning to enable this process and had liaised with people and their relatives to involve them and to explain the processes involved.

In another scheme, a family member had written to the manager of the service and described the work undertaken by staff as, "Truly amazing" in helping their family member settle into a supported living scheme. The relative felt the family member now was "having fun with their housemates" and "gaining so many skills." The provider had supported the person to transition into a household with people who already lived there. The manager described meeting with the person, their family and professionals on a number of occasions to get as full a picture as possible as to how to support them.

The manager had undertaken a detailed assessment and took into account assessments undertaken by the commissioning body and health professionals. The person had very complex needs and the manager explained they arranged a very gradual staged transition programme. The transition process stopped when the person had to go into hospital and began again when they were well enough. This was to ensure they could rebuild their familiarity with the people and staff. There was a detailed support plan in place to ensure all staff were familiar with the person's needs.

To support staff work effectively with people who had behaviour that challenged the service the provider had a number of teams within the organisation that offered training and support to staff and managers to ensure that people received effective care and treatment. We saw some excellent examples of where people with complex behavioural support needs that challenged the service were successfully supported to move into their new accommodation. One person previously had three staff with them to keep them safe but now could live in their flat with one staff member supporting them. This allowed them to live a more relaxed and 'ordinary' life and they had begun to explore different activities widening their life experiences.

In particular, Certitude's intensive support team had shared their expertise in a scheme where younger people were in the process of transition from home to supported accommodation. The intensive support team had trained staff to work with specific people to help them understand the person's behaviour utilising positive behavioural support, which is a non-restraint model of support. We saw that there was a real impact on people's lives because they could live without such a high level of staffing that they had before.

One staff member told us they had been well supported by their manager and the intensive support team to manage people's behaviour, "The positive behavioural support team gave us advice, and so did our manager." We saw their manager had led training in positive behavioural support for the staff team therefore the staff team were all working using the same unified approach that benefitted the people living

in the scheme.

Staff had undertaken work with people who had complex needs to support them to attend hospital and dentist checks without becoming upset or frightened. A care worker described using "social stories" to help people with this. Social stories are stories about an issue or matter that are written and developed in a specific way for people who have autism to develop a greater social understanding about a situation. To enhance the impact of the social story one staff member videoed the hospital building, the clinic and staff the person would meet when they visited. The social story and the video that the staff member had prepared helped the person understand what would take place and familiarised them with new faces and the hospital. The visit was successful and the person had received necessary dental treatment, as a result, of the care staff proactive and innovate work.

The provider had supported people who were at risk of poor mental health to attend a project called "Food for Thought." The initiative was aimed at improving the emotional wellbeing and mental health of people with a learning disability and included weekly sessions in a counsellor facilitated group. The sessions took place at the provider's activity centre and the group met over a meal and discussed topics relevant to them in a safe and comfortable environment. The project was proactive in taking measures to support people's well-being by offering a welcoming space to discuss concerns. There was an aim that people would develop their own support network through the group and in doing so improve their emotional wellbeing on an ongoing basis. Information sharing also took place flagging support agencies such as The Samaritans.

Staff supported people to maintain a healthy lifestyle. One person told us how care staff had supported them to lose weight they said, "Staff helped me lose weight, stopped chocolate and not [eat] too many cakes." Care staff supported people to eat a healthy diet. People's care plans stated what support people required. For instance, one person's care plan stated, "Support me to choose only halal meat and healthy food."

Staff supported some people to cook in their own flat. People shopped and chose their food with staff advice and support. Other people lived in a shared house and staff supported them to decide what they would like to eat. One person told us, "Yes we make a menu. I choose Tuesday's dinner and we all choose Thursday and we have a roast on a Sunday." They confirmed they liked to eat together but could eat in their room should they wish to. In another supported living scheme care staff described that they used picture menus to support people to make meal choices. We saw they had a recipe book folder containing over thirty choices people could make with pictures of meals and the recipes for staff to follow.

We saw in people's care plans and their daily notes that staff in all the schemes, supported people to access health care and attend routine checks. Health care professionals such as the GP, district nurses and the chiropodist visited people in their homes. We saw evidence that staff had also made referrals to other community health professionals such as, occupational therapists, physiotherapists, speech and language therapists, and dietitians. Staff had supported people who used wheelchair services to have the appropriate equipment and reassessment. Staff also supported people to attend community clinics for routine yearly checks such as well woman checks.

Staff had supported people to attend hospital clinics such as neurology, gynaecology, and endocrinology on an ongoing basis. Staff provided the medical team with up to date information about people's conditions that they had monitored and recorded at the service. For example, where people had epilepsy a record of seizure activity was kept for the epilepsy nurse or consultant's information to help them review the person. Staff encouraged and supported people to attend so that they would receive well-informed and up to date ongoing care from relevant health professionals.

Staff were trained in first aid and had further training and guidance to manage conditions such as epileptic seizures. People had up to date hospital passports. These contained information for ambulance crews and hospital staff about the support a person might require should they go into hospital for treatment. The hospital passports contained information about the person's medical history and described how people communicated and understood information. This helped to ensure people received the appropriate support when they were in a hospital setting.

Staff confirmed they had received an induction prior to commencing their role. Staff comments included, "Really good training", "Fine, yes good" and "They flag it if compulsory training is due. It's not all compulsory. They ask if you are you interested in attending this." We saw that staff had received training that included first aid, fire awareness, manual handling in both practical and theory, medicines management, health and safety, food and hygiene, infection control, equality and diversity and person centred care approaches. One staff team which were working in a new scheme received bespoke training tailored to the support needs of the people moving into the scheme prior to it starting. As such, the induction included positive behavioural strategies, communication and autism training.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. People's care records contained information that informed staff what support people required to make a decision.

People's care plan gave guidance as to how a person demonstrated their choices. For example, one person's plan stated, "I make my wishes clear through a combination of facial expression, vocalisation, and body language." Recorded also in their care plan was "Support I need to make a decision." For example, for one person the support they needed was to make decisions about managing money. It was documented the person did not have the mental capacity to make decisions about larger amounts of money and a best interests decision had been made that in these cases money was managed by an appointee. However, the person was supported to make small purchases. Their care plan stated, "I must be given choice and shown different options." Other people's care plans referred staff to decision making agreements so it was clear what decisions the person could make and what support they required.

A number of people did not have the mental capacity to consent to their care and treatment. We saw that the provider had requested the supervisory body make applications to the Court of Protection in these cases to ensure that their care and treatment was in their best interests.

Good

Is the service caring?

Our findings

People spoke positively about their care staff. Their comments included, "My staff are really, really good", "I do like the staff and manager I think they are very helpful" and another said, "Yes they are kind."

Relatives' comments about the service were favourable. They included, "Very friendly, hospitable, and happy", "Yes, yes they do a good job", "The staff really look after my relative's well-being", "A kind, thoughtful, well-meaning bunch" and "Yes always very welcoming, with a smile." They went onto say, "And the staff members offer tea and coffee, also we are invited to birthday parties, it's like a family environment."

Staff were respectful when they spoke about people and spoke enthusiastically about people in very positive terms. For instance describing how inspiring they found people achievements saying that they had learnt from people. Certitude annual review in 2017 contained an interview with a staff member from the service who described,"[Service users] has inspired me from the first day I met her. She has an absolute determination to succeed. She views everyday as an adventure - Life is for living."

Staff promoted people's human rights and supported people to maintain relationships with their family. People's bedrooms often contained photos of family members. Care staff spoken with stressed the importance of supporting people to meet with their family. Their comments included, "Helping them to do what they want. [They] always want to see their sister so we take them for a visit." We saw one person's care plan stated that the person's mother was very important to them and when we observed a care staff member speaking to a person they said, "Lucky [service user's name] you are visiting your mum this afternoon, that will be lovely." The person looked very happy in response. Care staff supported other people in their relationships with their friends or partners and it was acknowledged in people's care plans as an important aspect of their life and well-being.

People's care plans specified clearly how people communicated their wishes and how they understood what was being said to them in order for them to make choices. For example, "I speak English but have a limited vocabulary" and "I make my wishes clear through a combination of facial expression, vocalisation, and body language." Another person's plan stated, "Always give [service user's name] information as succinctly as possible….give them time to reflect when introducing a new idea." In a number of care plans, we reviewed speech and language therapists had assessed people and their recommendations were used in communication guidance for staff.

We saw that staff were knowledgeable about different individual's behaviour and they told us they understood that behaviour was a means of communication for the person. Behavioural plans described how people used certain behaviours to tell staff how they were feeling or what they wanted to happen. Guidance specified, "If I do this - laugh", "It usually means - I am happy" and "[service user's name] needs us to - laugh with me".

We saw that staff responded positively to people who went through certain rituals to communicate and

control what was taking place. For example staff were able to explain to us what a person wanted us as visitors to do, before they would decide if they would welcome us into their home. Because of the staff support to tell us what the person wanted we were able to meet with the person and interact with them. We saw the information was in their care plans and staff had worked closely with behavioural teams and person's family to ensure they understood the person. The person no longer exhibited such a high degree of behaviours that challenged the service as their choices and wishes were now understood and being met. This had led to a reduction of staff on duty, leading to a more relaxed daily living experience for the person.

When people had complex needs, care staff were encouraged to use intensive interaction. This technique facilitates positive engagement with people who have a learning disability or who are on the autistic spectrum. Staff had received training to use the technique and posters displayed in the office reminded staff of its use by stating, "How can intensive interaction be used through the day." This meant that for people who had limited verbal communication staff could communicate in a meaningful way, by for instance, making eye contact, mirroring people's behaviour, and echoing their vocalisations through turn taking. We observed staff using this technique when communicating with people.

In addition, people's care plans specified when they used other means of communication such as Makaton. This is a way of communicating that uses signs and symbols. Staff were able to use the Makaton signs people understood. Care plans also highlighted when people used their own specific gestures or required a visual prompt to understand and to make choices.

The provider Certitude had undertaken fund raising events to finance electronic tablets for some people. Care plans contained guidance on how people used this equipment to make choices. For instance, one person used an electronic tablet to make choices about meals and activities. The care staff had programmed the tablet with the support of the speech and language therapist with photos of activities the person enjoyed. The photos were put in electronic folders so for example if a driver was available outdoor trips could be picked, if not local or indoor activities folders could be looked through. We observed the person clearly enjoyed using their electronic tablet and this allowed them to have control over what took place and express their choice clearly.

Care staff expressed how much they liked working in the schemes. Their comments included, "If you walk through the door you can see they are happy. It is their house not ours, they get on with each other like a big family" and, "I love it working here is a good experience for me. If you enjoy what you are doing you develop good relationships with people." Care staff and managers spoke in very positive terms about people and were very knowledgeable about people's preferences and choices.

People had key-workers. A keyworker is an identified staff member who has a particular responsibility for the person. They are a point of contact for other staff, professionals and for family members. The key- worker knew about the person in greater depth than other staff and as such, they had a special bond with the person. For instance, one person had identified in their review that they would like to buy an exercise step. The manager and key-worker had discussed this as an action for them to support the person to do this. We saw the key-worker had purchased the item and the person pointed out their exercise step to us.

In each scheme, there were always some staff on duty who were familiar with the people and usually there was a consistent staff group who in many instances had worked with people for many years. People's care plans referenced individual staff as a paid member of the person's circle of support and could tell us in detail about the person. The managers of each scheme demonstrated to us that they were very well informed about the people in their care. They spoke about people with great regard and respect. We saw managers had advocated for people's right to make choices. One commissioner described one manager as,

"An exceptional person…genuinely caring and compassionate." They described how the manager advocated on behalf of one person to make others aware of their right to make their own decisions.

People's care plans stated their privacy and dignity support needs. Care plans stated people's preferences as to a male or female staff when receiving personal care. Care plans stated if this was the person's preference and if this was a cultural or religious support need. People's preferences were described clearly. For instance, one person's plan described that they had epilepsy and was at risk of seizures and needed to be monitored whilst bathing. The care plan stated, "[Service user's name] likes privacy when having a bath/shower and does not like staff checking on them. It is important staff wait upstairs and listen out, when they shower in case of a seizure." This meant the risk to the person was mitigated and their privacy was maintained in a sensitive manner.

Care staff told us the importance of "Giving people space." We observed that people even when they required one to one staffing were supported at all times in a sensitive manner to give them opportunity to have private time alone whilst staff listened out for them.

In the services we visited people's information was kept in a secure manner so their private information remained confidential. Staff received training to ensure they completed records in a positive and non-judgemental manner and records seen were appropriately completed. The provider told people how their information was maintained in accordance with the law in an easy read leaflet. The easy read leaflet explained to people what records were kept, that they had a right to see their records and told them how they could request to see them if they wished. Therefore, the provider promoted peoples' right to a private life, and gave people information should they wish to see what their records contained.

Good

Is the service responsive?

Our findings

People's care plan contained a profile that gave a thorough history of the person, and important events in their life including childhood details. This gave staff a clear picture of the person in the context of their life. People's plans contained their diversity support needs such as their religious and cultural observances. Care plans contained their "Circle of Support" that named important people in the person's life such as family members, friends, health and health and social care professionals and paid care staff.

Care plans recorded people's likes and dislikes in detail. For example, one person liked travelling and the countries they had visited included China, America, Kenya and Canada. For other people with complex support needs care plans contained a very detailed list of what people in their circle of support had observed was important to them. This included for example, their sensory beads, visits to temple, outings, parties, and talking with them about a favourite family member.

People's care plans were up to date and reviewed to reflect changes of circumstances. Care plans contained how the person liked their routine to take place stating for instance, "I currently prefer to wake up late…I would like staff to prompt me from 11am to get up." In addition, care plans informed staff how people knew it was time to go to bed in the evening and what support they required, such as support to say an evening prayer. People's care plans detailed the support they required with personal care. For instance, one person's care plan instructed staff to show picture of shampoos and conditioners so they knew their hair was being washed and could choose which brand to use.

People's care plans promoted their independence and stated what support they required and what they liked to do for themselves. One person told us, "I go out by myself. I don't like staff with me." We saw staff had respected this and the person went out in the local area with measures in place as identified in their risk assessment and care plan. The person's support needs were clearly stated in their care plan as what they could do for themselves and when they required support. They were managing their medicines. This had been risk assessed and was being reviewed on a three monthly basis. Staff monitored and checked this was working well. The person was very conscientious about taking their medicines and confirmed to us that they liked to have this independence.

There was a very good use of equipment and technology across the schemes to help meet people's needs and to give them greater choice and independence. One person who had both learning and physical disabilities had been supported to use an electronic voice assistant to request their favourite music to be played each time they came into the lounge. Staff described supporting the person to say the words so the device would understand. Once the device had been programmed, the person no longer needed staff support to switch on the CD player, and took great pleasure in doing this themselves.

People's care plans detailed the support they required to attend activities. For instance, one person's plan stated, "On the day of going out before leaving the house staff must remind me of where we are going, whom I am going with, both staff and others, the kind of transport I am going to use and what I will be doing when I get home." Other people's plans described their mobility equipment and specific measures to take

when travelling.

Care plans described what activities people enjoyed both inside and outside their home. These activities were person centred and individualised. One person was new to a service and their care plan described what staff had been told the person liked but read, "We are still learning what [service user's name] likes to do." This acknowledged that a range of activities needed to be introduced gradually to see if the person liked them or not. Staff supported people to undertake a wide range of activities tailored to their individual needs. For example, even if people who lived in the same scheme, they attended different activities each day according to their needs and preferences. Some people went horse riding, others visited the community farm, or day centres to play bingo or to make arts and crafts items. Some people preferred staff support to go to the shops, or a walk to visit a place of interest according to their choice, some had a hand massage sensory session or listened to their favourite music. Group activities took place in some services that people had chosen in tenants' meetings or that were staff suggestions. Recent trips included a visit to Winter Wonderland and theatre visits.

Staff had supported some people to travel abroad when it was identified as an aim of the person in their review. Some people supported by staff travelled abroad for the first time without their family members successfully. This promoted people's independence and gave them the opportunity to realise their goals and explore new experiences.

Some services we visited had access to the provider's community bus. The community bus enabled people who had both learning disabilities and physical disabilities including those who were wheel chair users to go to places that would otherwise be difficult to access by other means. Other people had a "Motability" car. Motability is a scheme that is intended to enable disabled people, their families, and their carers to lease a car using their government-funded mobility allowance. There were identified staff members who were drivers for specific individuals whilst another staff member supported the person in the Motability car. The use of Motability cars promoted people's independence and facilitated trips to both known favourite locations and to explore new areas to enhance people's life experiences.

Keyworkers had supported people with complex behavioural support needs go on trips and outings. For example, one person who loved football was supported to travel for the first time in their life to watch a live football match at their favourite club ground in another part of the country. The staff member who had organised and facilitated the trip described to us that the person had "Absolutely loved it." The staff member had also taken the person to meet Mo Farrah and Usain Bolt their sporting heroes. Other trips had included watching the pantomime Aladdin. The staff member told us they had found through arranging other outings that the person did not like going out at night, so they arranged and went to a matinee performance. The staff member spoken with demonstrated a passion and vision for the people they worked with. They held a strong belief that with the right planning and support people with complex behavioural support needs could lead the life they wanted to.

Managers had discussed with people and their relatives their end of life wishes. Their wishes had been recorded in their care plans. Some people's care plans included information about their funeral plans, where they would like their ashes kept or if they would like flowers at their funeral and if they had a favourite colour theme. On occasion, people did not wish to discuss the topic and care plans recorded "[Service user's name] does not wish to talk about this at the moment." Care staff had undertaken work with people to support them when a loved one such as a relative had died and helped them to understand and come to terms with what had happened by supporting them to visit the crematorium and the funeral directors.

One person told us, "We said goodbye to my friend." The manager told us how their friend, a person who

had lived at the house became terminally ill and had chosen to have their home as their place of treatment. They had a detailed end of life plan and staff supported them in their wishes. The manager and staff had talked with the other people in the house and helped them understand what was taking place. They had introduced them to the palliative care team who visited frequently and supported the care staff with the end of life care. They had advocated on behalf of the person who did not want to go into hospital.

Care staff had supported people in the house to choose a tree to remember the person and the person described to us scattering the ashes and saying a prayer. We observed the manager and care staff encouraged people to remember the person and express their feelings about their loss. The manager and care staff had been nominated won the regional Great British Care Awards in recognition of the care they had provided during the person's end of life care.

The provider Certitude had a complaints policy and procedure. Formal complaints were monitored at a senior level. The chief executive responded and acknowledged complaints. They appointed an officer to investigate. There was a clearly staged process with a timeframe for responses. Outcomes were reported to the board and statistic published in the annual report.

People told us they knew how to complain and that they would feel comfortable complaining. Relatives told us that they were encouraged to make complaints and that the managers were approachable. We saw that complaints were addressed by managers when people raised a concern. We saw there were easy read complaints guides available for people that were written in signs and symbols to tell people how to complain. Daily handover forms in the schemes contained a section asking if there had been any complaints and asked for staff confirmation that complaints or concerns had been raised with the manager.

Outstanding ☆

Is the service well-led?

Our findings

Certitude ensured people and their relatives had varied opportunities to meet with them to share their views and raise concerns and to fully engage and contribute to the development and the future planning for the organisation.

The provider held regular "Listening events" that were arranged as a lunch or an evening meal for people and relatives to share their views on the service given. The events were to ensure relatives were able to meet and speak directly to senior management staff including the board and leadership team. The leadership team addressed concerns raised. For instance, when one relative complained about communication at a supported living service, the leadership team acknowledged the complaint in a letter to the relative. A second letter was also sent to the relative to explain how the matter had been addressed by Certitude and what changes had been made because of their investigation.

The leadership team and board undertook a programme of visiting the individual services in 2017/18 to ensure they were familiar with the provisions, to assess the quality of care being provided at the schemes and to give people and relatives an opportunity to speak with them face to face and to share their views about the service. The registered manager demonstrated that they were knowledgeable about the people using their service. Service managers visited schemes on a weekly basis and managers confirmed they were very well supported by the provider.

Certitude had also held "The Big Event 2016" where people and families were invited to attend a day of entertainment, talks and workshops. The registered manager told us the aim of the day was for the event to be enjoyable, interactive, provide information and share knowledge." Representatives from different organisations with a focus on learning disability and mental health were invited to give talks and hold workshops. Certitude recorded that 470 people attended the event that was held in central London. The registered manager gave an example that one outcome from the event voiced by people was, "That support workers to listen." This message was shared with all staff and shared in training.

Individual supported living schemes held events that relatives were invited to attend. They had opportunities to raise concerns and to be kept informed of changes. One relative told us, "I've got no question that the staff are well managed. We've met some of the team on certain events we have been invited to and it's great. They work at a high standard, I've got no complaints."

The registered manager held events to ensure staff were fully engaged and involved in the development of the service. There was a very good culture of recognising and utilising staff skills across the service. For example a manager who had strong risk assessment skills was about to commence training with other services. We saw evidence of staff team building days where staff were encouraged to learn about new initiatives in the service and to share their own knowledge and skills by presenting a topic to their team.

The registered manager and provider celebrated and recognised staff achievements through a number of internal awards and nominated staff for national carers' awards. One staff team had been nominated for

The Great British Care Awards and were successful in winning the regional award for the Palliative Care nominations in recognition of their work in palliative care. A staff member told us they were both surprised and pleased to have their work recognised.

Care workers were also nominated for the internal "Excellence awards" and attended a presentation ceremony evening with the people they supported. There were a number of categories, the best colleague award, the change maker award, the making a difference award and the best volunteer award. There was also an overall award called the Michael Rosen Award described in the award booklet "as the ultimate accolade" for an individual or team "who through their work have clearly demonstrated Certitude's vision and values." People and staff spoken with who attended all described how much they enjoyed the award evening.

Blogs and newsletters celebrated the winning staff accomplishments. For example, two staff members had been recognised and celebrated as "Change makers" at the awards for excellence. They had supported two people to go on holiday for the first time without the support of their parents. In addition, other staff were congratulated when they had worked with a number of, "external stakeholders" to ensure one person's successful transition from hospital into a supported living scheme.

The registered manager described that Certitude worked with a number of learning disability groups to raise awareness of issues that affect people with learning disabilities. Certitude's Treat Me Right! Project empowered people with a learning disability to get better health services. The Treat Me Right! team employs people with learning disabilities as health champions and health trainers.

The Treat Me Right! Team was offering learning disability awareness training and they had recently met with a local MP to raise their awareness of issues affecting people with learning disabilities. The MP said in their blog on 21 November 2017, "I was inspired by the people and the staff supporting them and found out more about the amazing work Certitude does." The aim of the team was to extend their training across London to others including MP's at Westminster.

Certitude had supported some people living in the supported living schemes to work with a professional photographer to produce portraits of people with learning disabilities. These were to be displayed in Hounslow in a community exhibition to celebrate local diversity. The provider was therefore promoting a positive image of people with learning disabilities and their place in the local community. The photos were also displayed in some of the schemes we visited. This helped to promote individual's self-esteem and sense of worth.

Certitude had held a number of consultation meetings talking with people and their relatives who had been restrained in previous settings. The registered manager explained this was an on ongoing process and they were going to use the information from the consultations to develop a least restrictive practice strategy.

Certitude were working with other organisations to improve the standards for people with learning disabilities and for example supported people with learning disabilities and their relatives to attend courses with "Partners in Policy Making - In Control" an organisation that promotes people with learning disabilities should have the right to live the life they choose to live.

The provider Certitude had a vision statement for quality in the service, "That everyone has the right to a good life." Staff empowered people to live full lives and to have the life they wanted to live. Reports, blogs, and newsletters contained many references to people being supported to experience new activities and to live more independent lives. The registered manager told us with regard to quality assurance that "The

person is at the centre of it." They explained that it is the person's experience of the care they receive that is important. There was a very strong emphasis throughout the organisation that all care given must be person centred and that the quality of life for people with learning disabilities must be improved.

The Provider to support people living in the schemes to feel comfortable in speaking up arranged for "Quality Checkers" to visit the schemes. Quality Checkers are people who also use the Certitude services who take part in monitoring the quality of service provision and visit the schemes to check on aspects of the service such as activities and to speak with people and staff, and comment on the environment. They completed training to support them to undertake their role and this initiative offered a level of scrutiny and observation that was valued by the organisation.

Certitude circulated a "Quality Matters" publication approximately each quarter to staff working in the Support for Living services. In the November 2017 issue, feedback was published from the customer survey. There was a link to the website so staff could check what had been said by people about the provider and service they received.

The provider had a designated quality assurance team that monitored all the Certitude services including Support for Living Domiciliary Care Services. The team consisted of two quality assurance coordinators, a data performance analyst and two quality improvement partners and the head of quality assurance. It was their role to ensure the services provided were of a high quality. They worked alongside health and safety consultants to ensure all risks to the service were identified and well managed. Staff and managers recorded all incidents and accidents on a central databases which were monitored by the quality assurance team to provide oversight of risks within the service.

Managers of the individual supported living schemes completed comprehensive audits and checks each month and these were returned to the quality assurance team who analysed and compared the data across the schemes. There was an emphasis on ensuring there was consistent and high quality care across the schemes that are part of the service. All data was reported to the board for their oversight and scrutiny.

Audits by the quality assurance team took place in each service. Actions from each audit were rated as green, amber, or red that denoted the matter was urgent. Action plans were shared with the staff team and red actions were prioritised and addressed immediately. The registered manager, senior managers and managers had oversight of systems and progress through an accessible database.

We saw changes were being made as result of the quality assurance team oversight. They were driving up standards to improve people's experience of the care given. For instance, the registered manager told us audits had identified that not all documentation used in each supported living service was the same. Therefore, we saw that the provider was in the process of creating universal forms to be utilised across the whole service to ensure a unified and consistent approach.

We saw that managers and deputy managers checked the environment and daily notes to ensure the service and people were safe. Daily handover sheets instructed staff to check if tasks, such as, medicines administration, finances and the following day's rota were correct and ensured that any incidents or complaints had been highlighted to the deputy manager or manager. Weekly environmental checks took place and were recorded. Any faults were reported appropriately. Each manager audited all areas monthly to ensure, for instance, that people's records and information was reviewed and up to date and that staff supervision sessions and training were up to date.

The board had identified areas for improvement and there were individual projects to implement changes

and ensure the service was up to date with legislative changes. For example, we saw a very detailed staged project plan with regard to data storage and communications to address forthcoming legislation in regards to this. We saw that the most of the actions had been addressed prior to the timescales identified and that remaining actions were going to be completed within the timescales. There was therefore very good oversight by the board and a proactive approach to changes within the industry.

In addition, each service had their own action plans to support them to develop areas that had been identified from audit. These plans were kept in an open and transparent manner to ensure staff, people and their relatives could comment. For example, in one scheme we saw the plan was displayed in the office. It was written in an easy read style with pictures and photos to support understanding. The manager described this was a "working document" as improvement was always ongoing.

Certitude had a comprehensive leadership programme that encouraged managers to develop their skills to meet the demands of a changing service. Staff were encouraged to apply for senior roles. This occurred throughout the service. We met two care staff who had just been successful in becoming deputy managers. They told us managers and service managers had supported and encouraged them to apply for senior roles. This meant there was growth and development of the work force inside the organisation to ensure they had fully trained leaders equipped to understand the provider's vision.

The registered manager explained they were working with other similar sized organisations to compare and benchmark the service offered. This gave the organisation the opportunity to learn from other organisations' experiences and to compare where areas for improvement were needed.

The provider worked alongside a number of other charitable and voluntary organisations and kept staff informed about new initiatives and projects. The staff newsletter told staff about national initiatives by other organisations as for instance flagged reports such as "The State of Care" published by the CQC.

The provider was working in partnership with commissioning authorities. We spoke with a commissioner who confirmed that they had worked with Certitude to support people with complex needs. This meant that individual managers of services and their staff were working with local authorities, and local health care services to ensure good and quality care for people using services.