The Frances Taylor Foundation

The Frances Taylor Foundation Liverpool Adult Services

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 31 October and 1 November 2016 and was announced. The inspection was conducted by an adult social care inspector. At the time of our inspection there were 41 people who were using the service.

At the last inspection on 30 August 2013 we found the service to be compliant with all regulations we assessed at that time.The Frances Taylor Foundation is part of the UK charity, the Poor Servants of the Mother of God. Liverpool Adult Services is a supported living service providing community care and support to people with a learning difficulty mainly in the Liverpool area.

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.

Records showed that 100% of staff had completed training in safeguarding adults and people told us they felt safe receiving support from the service. Staff were able to clearly tell us what they would do if they suspected someone was being abused.

Each person who used the service had a 'working file,' a 'medicines file,' and a 'financial file.'

We found that the risks to people's safety had been assessed using a variety of risk assessments which were completed before and when people started to use the service and these were updated if their needs changed.

There was an accidents/incidents file in use for recording any accidents or incidents. Audits of accidents and incidents undertaken at each house.

Care staff we spoke with were experienced and knew how to respond in an emergency or when to offer assistance for a person's well-being.

There were sufficient staff to carry out the various roles within the service and each house held copies of the rota for the individual location address.

We looked at five staff personnel files and there was evidence of robust recruitment procedures in place.

Suitable arrangements were in place to ensure that people who used the service were safe. There was an appropriate and up to date medicines administration policy in use.There was a medicines competency check file in place and we saw that staff competence to administer medicines was regularly undertaken each month on a rolling basis.

There was a health and safety policy in place which gave guidance on infection prevention and control at each house we visited. All care staff had received training in infection control which we verified by checking records.

The service had a business continuity plan that detailed the action to be taken in the event of an unforeseen circumstance such as loss of utilities supplies, loss of IT/telephony, pandemic flu, adverse weather, lack of public transport, fire and flood.

People we spoke with confirmed that the care workers and other staff they met were competent. There was a comprehensive staff induction programme in place which was carried out over three days.

Staff we spoke with all told us they received an induction and on-going training in order to ensure they had the necessary skills to meet people's individual needs.

Staff told us they felt they had received sufficient training to undertake their role competently.

Staff received supervision and appraisal from their manager, and the service kept a record of all staff supervisions that had previously taken place.

Staff demonstrated a good understanding of MCA/DoLS and told us about when they felt a DoLS authorisation might be required. All staff had completed training in MCA/DoLS as part of the process of induction and through subsequent training.

Before any care and support was given the service obtained consent from the person who used the service or their representative and each section of people's care files had been signed accordingly.

Each person who used the service had a comprehensive health assessment and health care plan which was easily accessible within their individual care and support plan.

At each house we visited people's bedrooms were decorated to their choice and contained a wide variety of personal items that were relevant to each person.

People chose their own food and drink, had nutritional care plans in place and referrals to other professionals such as speech and language therapists (SALT) had been made where required, and information and advice received from these was documented. People's likes and dislikes were recorded in their care file and this was in pictorial format, which would assist some people with limited verbal and written communication to recognise the foods they liked.

People received support from staff who showed kindness and compassion. Staff knew the different ways that people communicated and people had communication care plans and risk assessments in place. The service had made written information easier to understand for people that required this.

People were treated with dignity and respect. We saw that staff knocked on people's doors and waited to be let in. The service used a 'matching tool' which helped to ensure a good match between the person using the service and the staff supporting them.

Involvement of people who used the service was embedded into everyday practice. People's support plans detailed things that people could do for themselves and what they needed support with.

People were involved in developing their care plan and were supported to be independent. Sensitive information was also being handled carefully.

The service did not provide end of life care and no-one was in receipt of this at the time of the inspection.

The service had a service user's handbook called Liverpool Adult Services Support Guide, which was given to each person who used the service. In addition to this people were also provided with a Statement of Purpose, which is a document that includes a standard required set of information about a service.

People had a weekly planner in their care files and this documented the activities that they enjoyed doing and had taken part in. People also had a 'care and support grid' document in their files which identified different tasks that needed to be completed each day.

People's care plans were reviewed on a monthly basis by their key worker and any updates were recorded correctly in their files. The needs of people were assessed by experienced members of staff before being accepted into the service and thorough pre-admission assessments were completed to ensure the service could meet people's individual needs.

People who used the service had a care plan that was personal to them. Copies were held at both the person's own home and in the main office premises. The structure of the care plans was clear and information was easy to access.

People using the service and staff told us that they felt confident talking to the registered manager directly with any concerns or complaints. The service had a complaints policy and procedure and we saw that they followed this consistently.

The staff we spoke with told us they enjoyed working for the service which had an open transparent culture. Staff also felt supported to undertake their roles to the best of their ability.

New developments were discussed within staff meetings, along with policies & procedures. All team managers encouraged the staff they were responsible for to contribute to staff meetings so that all staff felt included.

Staff supervisions records were held in individual staff personnel files which were kept securely, maintaining their confidentiality.

The service worked closely with Liverpool John Moores University (LJMU) in supporting student nurses with placements.

The service was registered with the Workplace Wellbeing Charter which provided advice and guidance to enable the service to continue to strive towards excellence.

The service was also registered with the Dignity in Care Charter and staff members had pledged their commitment to dignity in care.

The service had committed to the Health Charter for Social Care Providers. This charter was developed in partnership with the Voluntary Organisations Disability Group (VODG).

Staff had access to a wide range of policies and procedures. These could be easily accessed and viewed by

staff if they ever needed to seek advice or guidance in a particular area.

The registered manager undertook regular audits covering a wide range of areas and records of audits were comprehensive.

The service had a business continuity plan that was recently reviewed in September 2016 and also had a business development plan for the period 2016-2020.

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.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with told us they felt safe.

Records of medicines administration had been completed consistently and accurately. Accidents and incidents were recorded correctly.

Is the service effective?

Good

The service was effective.

Staff were aware of how to seek consent from people before providing care or support.

People's care plans contained records of visits by other health professionals.

Staff were subject to a formal induction process and probationary period and there was a staff supervision schedule in place.

Is the service caring?

Good

The service was caring.

Staff spoken with had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of laughter between staff and people and there was a positive atmosphere within the different homes visited.

The service involved people and their families when developing care plans.

Is the service responsive?

Good

The service was responsive.

Care files were well organised and contained information that covered a range of health and social care support needs.

Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

Is the service well-led?

Good

The service was well-led.

Staff told us they enjoyed their work and that there was a good culture at the home.

We found there were appropriate systems in place to monitor the quality of service.

Team meetings took place regularly, giving staff the opportunity to discuss their work and raise concerns.

The Frances Taylor Foundation Liverpool Adult Services

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 31 October and 1 November 2016 and was announced. The provider was given 48 hours' notice because the location is a supported living service providing community care and support to people with a learning difficulty who are often out during the day; we needed to be sure that someone would be in.

The inspection was carried out by an inspector from the Care Quality Commission (CQC).

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We also reviewed any safeguarding or whistleblowing information we had received, previous inspection reports and any complaints about the service. This helped us determine if there might be any specific areas to focus on during the inspection.

Prior to the date of the inspection the service submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we visited 13 people in their homes at three different locations and looked at six care records and related correspondence, five staff personnel files, quality assurance records, accident and

incident records and policies and procedures. As part of the inspection we spoke with the registered manager, the deputy service manager, two team leaders, seven support workers, the office administrator and three student nurses. We spoke with six people receiving support about their experiences of using the service.

Good

Is the service safe?

Our findings

People told us they felt safe receiving support from the service. One person said, "I feel safe and trust all the staff." Another person told us, "I like living here; the staff are very nice and are my friends." Not all people who used the service were able to talk with us about their experiences but two other people gave us a 'thumbs-up' and smiled when we asked them if they felt safe.

We also looked at feedback forms that had been completed by people who used the service and their families to determine their views on the quality of care. One form from a family member stated, '[My relative] is so happy in her new home; staff support has made it possible for [my relative] to grow in confidence and feel valued. This is a credit to your organisation.' Another form from a family member stated, '[My relative] is in very good hands thanks to your wonderful staff; they are a credit to your organisation and illustrating what your mission statement means in action.'

Staff told us they received safeguarding adults training. We verified this by looking at staff training records and saw that 100% of staff had completed this training. The service had a safeguarding policy and procedure in place which was available in each of the houses where services were provided. Where safeguarding concerns had been previously identified, these had been responded to and dealt with appropriately and records contained a safeguarding case chronology, the CQC statutory notification, correspondence relating to the safeguarding and case notes.

Staff completed a safeguarding workbook as part of the process of induction which helped them to understand their roles and responsibilities regarding safeguarding, how to keep people safe and how to raise any concerns or alerts.

Staff were able to clearly tell us what they would do if they suspected someone was being abused. They told us they would speak with the registered manager and if necessary contact the local authority safeguarding team and/or the police. One staff member said, "I would contact the team leader or the manager and we have different contact details for safeguarding and the police. We also do annual safeguarding training. Some of the signs of potential abuse would be people being afraid, bruising, and emotional or even acting differently than normal."

People's care plans were available in paper format in their own homes and by electronic information stored on a computer in each of the houses where people lived as well as in the service's main office. Each person who used the service had a 'working file,' a 'medicines file,' and a 'financial file.'

We found that the risks to people's safety had been assessed using a variety of risk assessments which were completed before and when people started to use the service and these were updated if their needs changed. We saw examples of risk assessments, which included assessing safety in the person's home environment, with moving them safely and if they had any particular needs that care workers should be aware of.

The service had also highlighted anything of importance or potential risk, such as if a person had a particular medical condition. The information included guidance regarding the actions the staff needed to take to keep people safe and risk assessments clearly highlighted if a person had other presenting risks, such as risk of falling, developing pressure ulcers or were at risk of dehydration and malnutrition.

There was an accidents/incidents file in use for recording any accidents or incidents. The file also included a pro-forma incidents form and the procedure for reporting any events. Incident reports had been analysed to identify if there were any concerns or patterns that the registered manager needed to address and these were a standing agenda item at the managers meetings.

Audits of accidents and incidents undertaken at each house identified the number of incidents since last audit, if a copy of the accident form had been placed in the person's care file, if a message had been placed in the staff message book informing them to read the form, if the organisation's directorate team and relevant other professionals had been informed, and whether lessons learnt had been formally reviewed and cascaded.

Care staff we spoke with were experienced and knew how to respond in an emergency or when to offer assistance for a person's well-being. They were all aware of contacting the office if they needed to feedback any important information and knew what to do if they thought a person was ill, such as calling the emergency services. There was an out of hours 'on-call' contact telephone number that was used if an issue arose out of normal office hours.

There were policies and procedures in place to guide and inform care workers who were lone working which were discussed as part of the process of induction and there afterwards.

There were sufficient staff to carry out the various roles within the service and each house held copies of the rota for the individual location address. Each person who used the service also had a 'care and support grid' document that identified the numbers of staff support hours they received and any support that was delivered on a 'one-to-one' support basis.

We looked at five staff personnel files and there was evidence of robust recruitment procedures in place. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

We looked at how the service managed people's medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. All staff administering medication had received training, which we verified by looking at training records. There was a medicines competency check file in place and we saw that staff competence to administer medicines was regularly undertaken each month on a rolling basis.

We looked at the medicines administration record (MAR) charts for people when we visited them in their own homes and found that these had all been completed correctly, were up to date and stored securely. Newly recruited staff were required to observe another staff member administering medicines to a person three times before they were allowed to administer themselves and after being assessed as competent to do so.

There was an appropriate and up to date medicines administration policy in use which included for example information on legislation, roles and responsibilities, training and competency, record keeping,

storage/administration/disposal and medicines to be taken 'as required' (PRN). Staff we spoke with told us they had received a copy of the policy. Where controlled medicines where administered we found that these were stored correctly and recorded appropriately. A protocol/procedure was also in place regarding how to safely manage medicines when people accessed the community or other facilities away from the home environment.

We looked at how the service managed the control of infectious diseases. Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use aprons and gloves when supporting people in their own homes. There was a health and safety policy in place which gave guidance on infection prevention and control at each house we visited. All care staff had received training in infection control which we verified by checking records..

The service had a business continuity plan that detailed the action to be taken in the event of an unforeseen circumstance such as loss of utilities supplies, loss of IT/telephony, pandemic flu, adverse weather, lack of public transport, fire and flood.

Good

Is the service effective?

Our findings

People we spoke with confirmed that the care workers and other staff they met were competent. One person told us, "I'm made up to be here and I settled down in no time. The staff are great and know what they are doing for me." Another person said, "Yes they know what to do." A third person smiled and gave us a 'thumbs-up' when we asked them if staff knew what they were doing.

We also looked at feedback forms and satisfaction surveys that had been completed by people who used the service and their families. Comments from people who used the service included, 'A very good service, could not do better,' and 'Frances Taylor Foundation has supported me at all times,' and 'They are a very good service.' One feedback form from a family member stated, 'I cannot suggest any improvement as they are doing a great job week in and week out.' Another relative feedback form stated, 'The service cared for [my relative] with great sensitivity and professionalism.'

There was a comprehensive staff induction programme in place which was carried out over three days and an 'on-site induction process' document was used to audit the progress of new staff in regards to meeting the requirements of the induction process. This covered areas such as health and safety, the use of equipment, food hygiene and related regulations, dealing with emergencies, service procedures, local facilities and the organisation.

Staff we spoke with all told us they received an induction and on-going training in order to ensure they had the necessary skills to meet people's individual needs. One staff member said, "I had a three day induction when I first started and this covered person-centred approaches. I also did a safeguarding workbook as part of this. By the time I started working in my current house I knew what things meant." A second staff member commented, "Yes I had a three day induction and had to complete an induction workbook. At the end I felt confident and understood more than I did at the start."

As part of the staff induction training there was discussion about the company's policies around safeguarding, the routes for reporting abuse including individual responsibilities from alerting and investigating cases of abuse, and the whistle blowing policies. This was verified by the staff we spoke with.

We saw that staff were given a copy of the organisation's policies and procedures which were available electronically or in paper format and staff knowledge of these policies and procedures was tested out at supervision meetings and as part of the process of induction. This meant that staff were clear about the standards expected by the service and how the service expected them to carry out their role in providing safe care to people in their own homes.

Staff told us they felt they had received sufficient training to undertake their role competently. One staff member told us, "Training is done every month, we revisit all topics previously covered each year to ensure we're up to date and usually get certificates for the training we've done. I've done training in dementia care, epilepsy, medicines management, pressure ulcer prevention, infection control, food hygiene and safeguarding." A second staff member commented, "We are trained regularly each month and I've done

training in safeguarding, MCA/DoLS, health and safety, infection control, food hygiene, dementia, first aid, pressure ulcer prevention and epilepsy. Training is useful to me and we can contribute to training courses and pose questions. I once requested to do NVQ3 in care and this was agreed by my manager and I've just completed it."

We reviewed the service's training matrix and staff training certificates, which showed staff had completed training in a range of areas, including dementia, safeguarding, first aid, medicines, Mental Capacity Act 2005, infection control and health and safety. We saw that additional staff training dates had been arranged throughout 2016 for a number of different courses including pressure area care, diabetes management, MCA/DoLS and autism awareness.

Staff received supervision and appraisal from their manager, and the service kept a record of all staff supervisions that had previously taken place. These processes gave staff an opportunity to discuss their performance and identify any further training they required. We found that staff were actively encouraged by managers to share their views and opinions through the mechanism of supervision.

Staff told us they received supervisions every two to three months in addition to an annual appraisal. We checked records to verify this. One staff member told us, "Supervisions are every two to three months and we also get the chance to attend group supervisions with colleagues who work in other houses in the area." A second staff member told us, "I get regular supervisions about every two months or so and we get a list of supervision dates in advance." We observed that a supervision schedule was posted on the staff room wall in all the houses that we visited.

We looked at how the service ensured there were enough staff available to meet people's needs and checked the staff rotas for the previous two months prior to the date of the inspection. Each individual location address (house) at which the service provided support to people had its own staff rota which was available to staff in advance and operated on a three week rolling basis. This ensured consistency and continuity of staff support and helped to contribute to building effective working relationships as the staff group at each house was familiar and consistent. We saw that the rota was posted on the staff room wall in all the houses that we visited.

We spoke with staff to ascertain their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). 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.

Staff demonstrated a good understanding of MCA/DoLS and told us about when they felt a DoLS authorisation might be required. One member of staff said, "We get training in this area. If somebody is unable to make decisions then one may be required." Another member of staff said, "We presume people have capacity initially, but if someone is really struggling with their own choices then they may need DoLS." A third staff member commented, "It's about carrying out the least restrictive practice possible, to keep people safe."

We found that all staff had completed training in MCA/DoLS as part of the process of induction and through subsequent training. This meant that the service had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general.

Care plans contained a 'mental health and emotional needs assessment tool' which identified each person's present situation and staff support needs in these areas. This enabled the service to identify how to best support the person and whether more specialist advice and support was required for example from a psychiatric consultant.

We looked at the way the service managed consent for any care and support provided and found that before any care and support was given the service obtained consent from the person who used the service or their representative and each section of people's care files had been signed accordingly. Consent included areas such as recording care plan information, use of photographs and sharing information with other professionals involved in the person's care and support.

One staff member said, "I'd ask the person before I did anything to make sure they understood and were okay with what I was going to do." Another staff member commented, "We always ask the person we are supporting for their agreement before carrying out any care and support."

We looked at how the service supported people to maintain good health and to access healthcare services. We found that each person who used the service had a comprehensive health assessment and health care plan which was easily accessible within their individual care and support plan. This gave clear information and appropriate guidance about people's individual health needs and how best to manage their on-going health issues. We also saw that the service completed a holistic assessment of people's wider health needs which included mental and emotional health, family and social relationships, lifestyle and culture, and daily living skills.

At each house we visited people's bedrooms were decorated to their choice and contained a wide variety of personal items that were relevant to each person. People chose their own food and drink. We saw menus in people's homes that reflected their likes and dislikes. We also saw that people undertook their own food shopping with the support of staff members where needed and as identified in their care plan. For example one person's care plan identified that they liked to do the weekly shopping and they confirmed to us that this is what they did. Where people required one-to-one staff support to access the community this was documented.

People had nutritional care plans in place and referrals to other professionals such as speech and language therapists (SALT) had been made where required, and information and advice received from these was documented. This provided staff with information on how to safely manage people's eating and drinking needs. One person told us, "I like the food here and I get a choice every day and staff try to get me what I want." A second person told us, "I've made my own ham and tomato sandwich for lunch today and I've done training in catering in the past." A third person said, "I'm happy with the food and I choose my own every day."

We saw that people's likes and dislikes were recorded in their care files and this was in pictorial format, which would assist some people with limited verbal and written communication to recognise the foods they liked. This also assisted staff in understanding how to communicate in a way that was meaningful to the person concerned.

Good

Is the service caring?

Our findings

People received support from staff who showed kindness and compassion. One person told us, "I like everyone in the house and the staff are great; I definitely trust them and feel safe." A second person said, "All the staff are very nice, I like living here because everyone is my friend." A third person commented, "The staff here are beautiful, always smiling and happy people and very caring."

Comments previously received by the service from people's relatives included, 'You have cared for [my relative] with great sensitivity and professionalism; always treated as an individual, tailoring her care to meet her needs,' and 'You have created a happy secure home for [my relative] where he can be the person he is and feel safe and valued,' and 'I'm always kept informed of [my relative's] health and care,' and 'You have given [my relative] the confidence to make a life for herself.'

Staff knew the different ways that people communicated and people had communication care plans and risk assessments in place. These documented how people preferred to communicate and guided staff on how to communicate effectively with them. For example, we saw how one person with a hearing impairment communicated partly by using sign language. We saw that their care file contained a variety of sign language gestures and symbols which helped the process of communication with this person. We found that this was reflected in the person's support plan and staff members knew about this person's communication methods.

The service had ensured written information was easier to understand for people when required . For example, we saw that the complaints procedure was written using pictures to aid people's understanding. We also saw that pictures were used with some people to support them to make choices about how to spend their time. We heard staff talk with people using their preferred methods of communication and, where needed, repeated and used words that they understood. This meant that people received information in ways that were meaningful to them.

People were treated with dignity and respect. We saw that staff knocked on people's doors and waited for a response before entering. We observed a handover where staff leaving their shift gave information to other staff coming onto duty. This was done verbally and also written down in the handover book. This was in addition to individual issues being recorded in people's care files. Staff spoke about people in a kind and person-centred way. We heard how people had spent their time, how their health was and how staff were reminding people to drink adequately. This demonstrated a caring approach to the people they were supporting.

The service used a 'matching tool' which helped to ensure a good match between the person using the service and the staff supporting them. Staff knew about the people they were supporting. Each person had an allocated keyworker who regularly reviewed their care plans each month or as necessary. This was in addition to a formal annual review of the care and support being provided. Each house held a list of when people's annual reviews were due. Annual reviews covered areas such as finance, capacity, understanding and recognition, independence, lifestyle opportunities, relationships, choice, health and the environment.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through well-developed person-centred care planning which ensured that each person had a person-centred plan in their care files. Support planning documentation used by the service enabled staff to capture information to ensure people from different cultural groups received the appropriate help and support they needed to lead fulfilling lives and meet their individual and cultural needs.

At each location we visited we observed lots of chatter and laughter between people using the service and the staff. For example if people were watching television active discussions were taking place about the programme being watched and how this related to their own life.

Involvement of people who used the service was embedded into everyday practice. The views and opinions of people were actively sought via the person's own method of communication and information was presented in a way that enabled people who used the service to fully participate and make informed changes, for example in pictorial format.

We saw that people's support plans detailed things that people could do for themselves and what they needed support with. For example, we read how one person was receiving support from staff to access new educational and training experiences. In this way they received support from staff to retain or learn new skills.

People were involved in developing their care plan. One person told us, "I'm involved in my care plan. Staff explain everything to me and I sign the plan." People's wishes regarding who was involved in their care plan was documented, for example one person's file stated, 'The only people I want to be involved in my plan are myself and my staff.'

People's sensitive information was being handled carefully. We saw that the provider had secure areas for the storage of people's care records and we saw staff making sure that people's information was stored correctly. We heard staff share information about people in a discreet and sensitive way so that conversations were not overheard by others. We also saw that the provider had made confidentiality and data protection policies available to staff. This meant that people's privacy was being protected by a provider who had suitable procedures and by staff who knew about these.

We found that most people were receiving support from a small number of regular staff members. This enabled the development of positive long-standing and trusting relationships between people who used the service and the staff who supported them.

People were supported to be independent, for example at one of the houses we visited we observed one person accessing their personal money which was securely held in a locked safe in the staff office and it was clear from our observations that this person was familiar with this procedure. We saw that the staff member took the person's personal tin that held their money and handed it to the person who then took the required amount of money out of the tin. They counted this in front of the staff member and were given a receipt for the amount debited, which was also recorded in the person's financial transactions record. The person told us that they accessed the bank themselves with the assistance of staff in order to draw out money to take home. This demonstrated that staff input was minimal with the person taking as much control over their finances as possible.

The service did not routinely provide end of life care and no-one was in receipt of this at the time of the inspection. However the organisation had previously supported people at the end of life and had the ability

to do so in future should the need arise. The provider had made information on advocacy services available to people. An advocate is a trained professional who can support people to speak up for themselves. Most of the people receiving support had a funeral plan detailing their own wishes regarding how they would like their funeral arrangements to be met. This was discussed with the person to ensure their wishes were recognised and treated with dignity and respect.

The service had a service user's handbook called Liverpool Adult Services Support Guide which was given to each person who used the service in addition to the Statement of Purpose, which is a document that includes a standard required set of information about a service. These documents provided a wide range of information such as the care philosophy; principles and values that the service followed; the standards of care that people should expect; details of the registered manager and nominated individual; a description of the services and facilities provided; how to make a complaint, confidentiality and dignity and respect.

Good

Is the service responsive?

Our findings

A person who used the service told us, "I go out shopping regularly and to the choir every Wednesday; I've been singing all my life. The staff at the office organised the choir group and I joined this." A second person said, "Sometimes I go out for a meal and have a diet coke." A third person told us, "I play the guitar and it's in my room and I play a few chords as well. I went to Blackpool lights recently."

Another person told us how they had an interest in dementia and had accessed training to enable them to become a 'dementia friend.' There was a sign in their house identifying the names of people who had also become dementia friends. The person gave us a tour of their home and proudly showed us a 'sensory room' that was used for both relaxation and stimulation which they told us they enjoyed using. They said, "My room is lovely and it's decorated exactly how I like." Two other people we spoke with told us how they were accessing numeracy and literacy classes in the local community in order to increase their knowledge and skills in this area, which we observed during the afternoon of the inspection.

A member of staff said, "When I go out in the community I've noticed that people can be judgemental and disrespectful to the person I support, so I'm always mindful of this and careful of how I support them."

We looked at feedback recently received from people who used the service and their relatives. We saw that satisfaction surveys were carried out every three months. Comments received included, '[My relative] is blossoming again. Staff support has made it possible for her to grow in confidence and feel valued by the people she shares her home with; this is a credit to your organisation, and 'Frances Taylor Foundation has supported me at all times,' and 'A very good service; could not do better.'

Feedback from a community health care professional stated, 'You are a wonderful team and keep doing what you are doing as it's fabulous. It has been a pleasure to have worked with you all.'

People had a weekly planner in their care files and this documented the activities that they enjoyed doing and had taken part in, for example one person had taken part in or had accessed sign language classes, the gym, personal shopping, the bank, cleaning their own room, evening meal out and walking for recreation during the course of one week. Another person who was interested in health and fitness had taken part in walking football, Zumba exercise classes, social club and multi-sports and fitness classes at several local community facilities.

We saw that one person who had an interest in communication technology had set up a 'Skype' account to enable electronic communication with their friends and family. This enabled constant communication to a wider circle of friends.

People also had a 'care and support grid' document in their files which identified different tasks that needed to be completed each day such as assistance with breakfast or personal care, the time the activity was required and the number of staff involved. This ensured that staff were aware of people's health and care needs.

People had a section in their care files which identified their immediate wishes, called 'goals.' We saw that one person had identified the need for a new bedroom carpet, a vanity unit, sink and matching wardrobes for their bedroom and this had been provided.

People's care plans were reviewed on a monthly basis by their key worker and any updates were recorded correctly in their files. This was in addition to a rolling programme of annual reviews. Keyworker sessions had a structured approach and were used in a proactive manner with outcomes monitored and recorded in each person's person-centred-plan.

We looked at how new referrals to the service were assessed. The needs of people were assessed by experienced members of staff before being accepted into the service and thorough pre-admission assessments were completed to ensure the service could meet people's individual needs. This included gathering background information from a variety of sources including other health and social care professionals and from those individuals who were important in people's lives.

We saw that prior to any new package of care being provided a pre-assessment was carried out with the person and their relative(s) which we verified by looking at care records. Before care and support was provided to any person the service completed a series of initial assessments which covered areas such as health, medicines, social history, mental health, preferred activities, moving and handling, environment.

People who used the service had a care plan that was personal to them with copies held at both the person's own home and in the main office premises. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care.

The structure of the care plans we looked at was clear, comprehensive and person centred and the information was easy to access. We noted care plans contained details regarding the person's background and life history, interests and social life, any existing support network, spiritual needs and recorded details of people who were involved in care planning such as family members and other relevant professionals.

There were systems in place to record what care had been provided during each day and night. Care plans contained a document, which was completed by staff throughout the working day. This included when personal care had been provided, any food preparation, medicines given or any creams applied. We checked these documents and found they were being filled in correctly by staff and were signed and dated.

People told us that should there be a need to complain they felt confident in talking to the registered manager directly. The service had a complaints policy and procedure and we saw that they followed this consistently. All staff were made aware of the policy at induction and a copy was kept on the individual files of the people receiving support. We saw evidence where complaints had been recorded and investigations had been carried out following issues raised.

Good

Is the service well-led?

Our findings

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.

An up to date registered manager's certificate was on display in the office premises in addition to an appropriate certificate of employers' liability insurance.

The staff we spoke with told us they felt able to approach the registered manager, report concerns and enjoyed working for the service which had an open transparent culture. One staff member told us, "Personally speaking I think the Trustees are the most warm and caring people I have ever met. My relationship with managers has been good at all levels, it's been really nice; I would absolutely be listened to if I had anything to say and the registered manager is concerned for our welfare." A second staff member commented, "It's a lovely company to work for. Everyone is supportive including my line manager and I get regular supervisions." A third staff member said, "The service cares about their staff and I have no issues; the registered manager is very good and I feel confident in raising any issues I have."

Comments previously received from relatives of people who used the service included, 'You make me feel like I can call you anytime which is very important to me,' and 'I am always kept informed of [my relatives] health and care.' When asked about if there was anything that could be improved in the service comments received included, 'Nothing, I am very satisfied,' and 'I really don't have any complaints,' and 'If anyone wants to hear about an example of good practice just tell them to speak to me.'

Staff also felt supported to undertake their roles to the best of their ability. We looked at the culture within the service and how staff members contributed to its development. We found that following discussions with team managers and staff teams the service had agreed to complete staff meetings every eight weeks and notes of these meetings were made available to all attendees. In addition managers meetings took take place every month and this had also been decided with the management team as being more proactive, enabling items on the agenda to be more specific resulting in more outcomes being met. Staff contributed to forming the agenda and were actively encouraged to participate.

New developments were discussed within staff meetings, along with policies & procedures. All team managers encouraged the staff they were responsible for to contribute to staff meetings so that all staff felt included. Staff were encouraged to express their opinion at staff meetings so that views could be openly aired to promote a positive culture. For example we found that staff had previously identified the need for there to be a working computer in each of the houses in which a service was provided, and this had been provided.

Policies such as dignity at work and safeguarding were discussed at staff meetings so staff know what was expected of them, both as a team and individually and one policy was discussed at each team meeting. Staff

meetings had an action plan that identified the actions needed to be taken and this was followed up at the next staff meeting to ensure all required activity had been undertaken. We verified this by speaking to staff and looking at historical records of meetings.

Staff supervisions records were held in individual staff personnel files which were kept securely, maintaining their confidentiality.

The service worked closely with Liverpool John Moores University (LJMU) in supporting student nurses with placements which was beneficial to the student nurses in helping them to understand about a wider range of people's different needs and how these needs were met by the service.
An induction pack had been produced, which we saw during the inspection and this had been discussed with LJMU and considered issues related to people living with a learning difficulty, what was expected of student nurses when they carried out their placement in someone's home and also what they could expect from the organisation.

After each placement an evaluation form was completed and the comments recorded on previous evaluation forms that we saw were all very positive. All the student nurses we spoke with strongly agreed that they had been provided with the information and support they needed both prior to, during and after their placement had been completed. One student nurse told us "It's wonderful working here; this is just like a normal household."

LJMU had also recently been in correspondence with the service regarding their ability to accommodate first year MA Social Work student placements and this was due to commence shortly after the date of the inspection. The deputy manager at Frances Taylor Foundation had also discussed with LJMU their interest in undertaking the practice educator course in order to better accommodate these future placements and were carrying out further research into this matter at the time of the inspection. This demonstrated that the service was pro-active in identifying their infrastructure needs.

The service was registered with the Workplace Wellbeing Charter which provided advice and guidance to enable the service to continue to strive towards excellence. The workplace wellbeing charter was launched as a national systematic method for improving health and is a way of giving employers a checklist, or toolkit, for improving and embedding good workplace health practice.

The service was also registered with the Dignity in Care Charter and staff members had pledged their commitment to dignity in care. This meant that the service had access to a wealth of resources and practical guidance which helped in developing their practice, with the aim of ensuring that all people who receive health and social care services are treated with dignity and respect.

The service had also held a Dignity Challenge Awareness Session for people they supported in February 2016 and the organisation's Dignity Do's and Dignity Don'ts was issued to every person being supported and staff members. The dignity do's and don'ts pledges formed part of the process of staff induction and described the values and actions of a high quality service that respects people's dignity who are in receipt of a care service.

Another initiative that the service had committed to was the Health Charter for Social Care Providers. This charter was developed in partnership with the Voluntary Organisations Disability Group (VODG). The health charter for social care providers is designed to support social care providers, working in partnership with their health colleagues, to tackle some of the health inequalities that people with learning difficulties experience.

The service also attended meetings with the Liverpool Social Care Partnership (LSCP) who's goal was to provide the very highest quality training, information and support services to their members and to promote the benefit and welfare of the inhabitants of Liverpool by offering to people who used the service, their carers and care providers, a range of training, information and support, in addition to consultancy around quality assurance, inspections and developing new business opportunities.

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, health and safety and infection control. These could be easily accessed and viewed by staff if they ever needed to seek advice or guidance in a particular area.

We looked at the systems in place to monitor the quality of service. The registered manager undertook regular audits covering areas such as care files, involvement by people who used the service, COSHH, medicines management, accidents/incidents, risk assessments, communication, staff records and supervision, service user's money and petty cash, policies and procedures, reporting systems and the annual business plan. From these an action plan was developed and we found by looking at documentation that actions previously identified had been carried out and an update had been circulated to the management team.

The service had a business continuity plan that was recently reviewed in September 2016. This included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and coordinated manner.

The service also had a business development plan for the period 2016-2020. This held details of activities that were required to be undertaken to develop the business and improve their quality. Areas for development included: the development of an assessment centre to incorporate Qualification Credit Framework (QCF); to continue to train staff on the requirements re the five key questions that CQC ask; to continue to develop the Quality Assurance Group, Complaints Committee and Tenants Committee and Focus Group.

There was a Statement of Purpose and Support Guide for people who used the service in place and each person was given a copy of these documents. Under the Health and Social Care Act 2008 every registered provider must have a Statement of Purpose, which is a document that includes a standard required set of information about a service. We saw the support guide was in pictorial format which assisted people who had difficulties in recognising written communication.