Social & Community Services

Oxfordshire Shared Lives Scheme

Inspection report

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Website: www.oxfordshire.gov.uk/sharedlives

Date of inspection visit:
05 October 2016
06 October 2016

Date of publication:
21 November 2016

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

We inspected Oxfordshire Shared Lives Scheme on 5 and 6 October 2016 and it was announced.

The Shared Lives Scheme is responsible for approving, training and monitoring 'shared lives carers' who provide personal care and support to people (on placements), living with them in their family home. At the time of this inspection the Scheme employed 10 social workers and had 68 approved 'shared lives households' who supported 111 people in placements. At the time of our inspection 19 people were receiving the regulated activity of personal care.

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.

Relatives told us people were safe. Staff and shared lives carers understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. Staff and shared lives carers had completed safeguarding training.

People were supported by shared lives carers who had the skills and training to carry out their roles and responsibilities. The nature of the service meant shared lives shared lives carers and their families built strong caring relationships with the people they supported. People lived as part of shared lives shared lives carers families and were involved in day to day events and family activities.

The service sought people's views and opinions and acted upon them. Relatives and shared lives carers told us they were confident they would be listened to and action would be taken if they raised a concern.

Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff and shared lives carers were aware of people's needs and followed guidance to keep them safe.

People received their medicines as prescribed. Records confirmed where people needed support with their medicines they were supported by shared lives shared lives carers that had been appropriately trained.

Staff spoke positively about the support they received from the registered manager. Staff had access to effective supervision. Shared lives carers were also positive about the support they received from the team of social workers.

The service had robust recruitment procedures and conducted background checks to ensure staff and shared live shared lives carers were suitable for their role.

The registered manager and staff understood the Mental Capacity Act (MCA) 2005 and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves.

Staff and the registered manager shared the visions and values of the service and these were embedded within service delivery. The service had systems to assess the quality of the service provided. Learning from audits took place which promoted people's safety and quality of life.

People were supported to maintain good health. Various health professionals were involved in assessing, planning and evaluating people's 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. Relatives told us people were safe.

Staff and shared lives carers understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse.

The service had a recruitment process which ensured that shared lives carers were suitable to work with vulnerable people.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective. People's dietary and nutritional were met.

Staff and shared lives shared lives carers had the training, skills and support to meet people's needs.

People were supported by staff who had been trained in the MCA and applied it's principles in their work.

The service worked with other health professionals to ensure people's physical health needs were met.

Is the service caring?

Good

The service was caring.

Shared lives carers were kind and respectful and treated people with dignity and respect.

People's individual, diverse needs were respected by shared lives carers who understood equality and diversity.

People benefited from caring relationships.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed to ensure they received personalised care.

Shared lives carers understood people's needs and preferences.

People were provided weekly activities as part of the shared lives agreements.

Is the service well-led?

Good

The service was well led.

The manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff. Staff knew how to raise concerns.

The service worked in partnership with visiting agencies.

Oxfordshire Shared Lives Scheme

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 5 and 6 October 2016 and was announced. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. The inspection was carried out by one inspector.

Before the inspection, the provider completed 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. We looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern.

We spoke with three relatives of people who used the service because people who received personal care as part of the service were not able to speak with us over the phone. We also spoke with four shared lives carers, four social workers, two senior practitioners, the administrator and the registered manager. We reviewed six people's records, four staff records and records relating to the management of the service.

Good

Is the service safe?

Our findings

Relatives we spoke with told us people were safe. Comments included "Yes [person] is safe", "He's always happy to go back to [carer]", "[Person] would tell me if he wasn't happy", "[Person] would tell me if there was a problem" and "We have no concerns about safety".

People were supported by shared lives carers who could explain how they would recognise and report abuse. Shared lives carers told us they would report concerns immediately to the shared lives scheme. Comments included "I would report any concerns back to the staff", If it was out of hours then I would ring the out of hours number", "I would ring the duty social worker", "I would contact the social worker straight away, if for some reason I did not feel listened to then I would go straight to [registered manager]" and "I would contact the care manager".

Shared lives carers were supported by qualified social workers (hereafter staff) who understood the services internal safeguarding procedures. Staff told us they would report concerns immediately to the registered manager and senior practitioners. Comments included "I would report it straight away to [registered manager]", "I would inform the [registered manager] and put immediate measures in place to safeguard the individual" and "I would report it directly to [registered manager] and include her boss in any correspondence".

Staff were also aware that they could report concerns externally if needed. Comments included; I would contact the safeguarding team", "I would notify the CQC (Care Quality Commission)" and "I would report it to the police or CQC if I had to".

People's care plans contained risk assessments which included risks associated with; moving and handling, nutrition, medication, choking, falls, personal care and risks associated with people being in the community. Where risks were identified plans were in place to identify how these would be managed. For example, one person was at risk of incontinence whilst being out within the community. The person's care record gave guidance for shared lives carers to mitigate this risk by ensuring that people and shared lives carers became familiar with new environments when visiting new places within the community. We spoke with the person's carer who told us "We prepare [person] before we go out into the community, this can be the day before or whilst we are out. It's about keeping [person] informed".

One person was at risk of scalding. The person's risk assessment included guidance for shared lives carers to ensure that the person's bath was at the correct temperature and what first aid action to take if scalding did occur. We spoke with this person's carer who was aware of this guidance and followed it. They told us "We constantly have to check water temperatures". We noted that a review of this risk was followed up by staff during 'support and monitoring' visits.

Another person was at risk of increased behaviours due to a change in personal circumstances. We noted that the person's social worker had put plans in place to mitigate this risk. We spoke with this person's carer and they told us "They put plans in place to make sure that [person] is supported". A relative of this person

told us "They have always seemed to do what they can for [person]".

Records confirmed where people needed support with their medicines they were supported by shared lives carers who had been appropriately trained. Shared lives carers had their competency assessed prior to supporting people with their medication. People's individual medication administration records (MAR) were completed on a daily basis by shared lives carers. MAR charts were then checked by staff during 'monitoring reviews'. Shared lives carers had their competencies re-assessed on an annual basis. One carer we spoke with told us "I do refresher training every year". Another carer told us "We have to be re-assessed every year".

Shared lives carers applied to join the scheme by completing a detailed application form which included background, work histories and reasons for joining. They were interviewed and assessed by staff and a detailed assessment which was then presented to an independent panel. The assessment specified the type of care (respite, long term or both) and the number of people the person could offer a home to. The panel consisted of professionals and 'experts by experience'. An 'expert by experience' is a person who has personal experience of using this type of care service. This meant that the service carried out its selection process in a way that incorporated the 'service user's voice'. The service then looked carefully at individual needs to ensure the carer could safely meet the needs of the person in their home. This was a safe method of ensuring only suitable shared lives carers were approved.

Shared lives carers underwent background checks to ensure they were safe to work with people. These procedures included Disclosure and Barring Service checks to confirm shared lives carers did not have a criminal conviction that prevented them from working with vulnerable adults. The service asked for references one of which was from the shared lives carers GP. References were always checked and verified as necessary.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised. These included employment references and Disclosure and Barring Service checks (DBS). These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Shared lives carers were self-employed and therefore not directly employed by the scheme. However, they were expected to adhere to a contract and policies and procedures and attend training. The service could place restrictions on shared lives carers or de-register them if it were deemed necessary to protect people.

Good

Is the service effective?

Our findings

Relatives we spoke with told us staff were knowledgeable about people's needs and supported them in line with their care records. Comments included "[Carer] knows [person] really well", "I have no problems they know [person] very well, they have cared for him for years" and "[Carer] knows what [person] routines are and what she likes".

People were supported by shared lives carers who had the skills and knowledge to carry out their roles and responsibilities. Shared lives carers told us and records confirmed that they received an induction and completed the schemes mandatory training prior to supporting people. This training included medication, safeguarding, mental capacity, equality and diversity and person centred support. The induction for shared lives carers was aligned to a national certificate in care. Shared lives carers spoke positively about the training they received. Comments included; "The training is very good", "I like the training, it is good" and "We do training in safeguarding, manual handling, medicines and first aid. Yeah it's alright".

Records confirmed and staff told us they received and had access to regular training opportunities. One staff member told us "I really enjoy the training aspect of my role". Another staff member described to us that they had recently attended specialist training for supporting people with autism.

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

Shared lives carers were supported by staff who had been trained in the MCA and applied it's principles in their work. All staff we spoke with without exception had a good understanding of the Act. Comments included, "Mental Capacity is decision and time specific", "A person may lack capacity in one thing but not other things", "Capacity should always be assumed until proven otherwise. We are not here to stop people living their lives", "Our service users have been judged all their lives in relation to not having capacity. It needs to stop here", "We have the act to support and safeguard people who may lack capacity" and "Best interest decisions must be based on the least restrictive option". We noted that one senior practitioner also held the role as a best interest assessor within the local authority.

People were supported by shared lives carers who understood their responsibilities in reporting any changes to people's mental capacity to the staff team. One carer we spoke with told us "I would get straight on the phone and ring my social worker". Another carer told us "If I had any concerns I would report it straight away to the office".

Care records contained information relating to people's capacity to make specific decisions. For example one person's care records demonstrated how a best interest decision had been made in relation to a person managing their finances. Another person's care records demonstrated how the service had considered a

person's capacity to make long term decisions in relation to their care needs.

Records confirmed and staff told us they received regular supervision (a one to one meeting) once a month by a senior practitioner or the registered manager. They felt they were well supported by the registered manager and senior practitioners. Comments included "(Senior practitioners) are very supportive", "(Senior practitioners) are brilliant, I even tell my family and friends about how supportive they are", "[Registered manager] supports us well, you can ask her any question at any time of the day" and "I find supervision really useful. We set actions and [senior practitioner] is responsive".

Shared lives carers were supported and supervised by staff who were all qualified social workers. Shared lives carers told us and records confirmed that they received regular 'support and monitoring' meetings and an 'annual review'. Shared lives carers told us they felt supported by staff. Comments included "(Staff) are wonderful, I get support any time I contact them", "It's nice to know that they are there if I need them", "I feel listened to" and "The support has always been really good". Where safeguarding concerns had been raised for people using the service we noted that additional support meetings had been put in place for their shared lives carers.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, dentists, opticians and district nurses. For example one person was supported by their carer to attend annual health reviews. Care records highlighted people's dietary requirements and allergies. Relatives we spoke with told us that shared lives carers followed this guidance.

Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, one person had been identified as having swallowing difficulties and a referral had been made to Speech and Language Therapy (SALT). Care records contained details of recommendations made by SALT. We spoke with this person's shared lives carer and they were aware of and followed this guidance.

Good

Is the service caring?

Our findings

Relatives told us that people benefited from caring relationships with shared lives carers. Comments included "From what I see [carer] is very caring", "The care is wonderful", "[Carer] looks after [person] really well" and "She is very caring". We also noted that people's care records contained compliments from healthcare professionals about the high standard of care that people received from shared lives carers.

Staff were committed to the scheme and made sure that people were supported by kind and caring shared lives carers. One member of staff we spoke with told us "I love this role, no two days are the same. Seeing the difference it makes to people is brilliant, not just the service users but the shared lives carers as well, it's great". Shared lives carers were enthusiastic about supporting people. Shared lives carers comments included "We will always do whatever we can for [person], I will do everything I can to support her wellbeing", "It's going to happen to me one day where I am going to need some help and support", and "I find being a carer really rewarding".

We asked shared lives carers how they promoted people's dignity and respect. Shared lives carers comments included; "We always make sure doors and windows are closed when we are supporting [person]", "We always make sure things happen in privacy" and "We promote dignity and respect in everything we do, for me the biggest aspect of this is about giving choice and options to people about their care".

Shared lives carers we spoke with told us the importance of informing people of what was going to happen during care. One carer said "I just think of how I would like to be treated, its common courtesy".

People were supported to remain independent. Shared lives carers we spoke with told us how they supported people to do as much as they could for themselves. One carer we spoke with told us "It's important to promote [persons] independence, for example [person] can (carry out aspects of personal care), so we acknowledge this and wait outside the bathroom and just keep checking he is alright, independence is really important to [person]" and "Independence is also about giving choice, it's important. Even though I know his likes and dislikes, it's important that he feels that he still has a choice". Another carer told us "It's about giving [person] as much choice as possible, we just want her to do as much as she possibly can".

People's individual, diverse needs were respected by shared lives carers who understood equality and diversity. Before shared lives carers were approved they were assessed by staff and asked questions about their attitudes to issues such as discrimination, disability, religion and other cultures. Shared lives carers we spoke with told us how they would challenge prejudice, discrimination and oppression. One carer we spoke with told us "It can happen quite often when we are in the community. I find that if you start with having a quiet word with someone it works, there is always a nice but firm way of challenging attitudes and beliefs. The most common issue for us has been about accessibility".

The nature of the service meant shared lives carers and their families built strong caring relationships with

the people they supported. People lived as part of shared lives carer's families and were involved in day to day events and family activities. One carer we spoke with told us "I have grown up with the service users, they are part of our family" and "[Person] has got to know the wider family. It's called shared lives for a reason and that's how it should be. I wouldn't have it any other way". A relative we spoke with told us "[Carer] takes [person] shopping to her favourite shops, she knows where she likes to eat out and takes her out for meals", "[Carer] also supports [person] who she gets on well with, so she will try and arrange meals out that they can both attend because they enjoy each other's company so much".

People received personalised care. For example, one person who had difficulties communicating was supported by shared lives carers who used 'objects of reference' to communicate effectively. This included the use of small models of common household facilities to support the person in communicating their care and support needs. This information was included within the person's care records. Another person who had difficulties communicating was supported by shared lives carers who used Makaton (Makaton is a communication method that uses signs and symbols) to communicate effectively with the person.

Good

Is the service responsive?

Our findings

Relatives we spoke with told us shared lives carers were responsive to people's changing needs. Comments included: "(Shared lives carers) are absolutely responsive", "If there is something that needs sorting out, then they do it" and "If ever there is a problem then they're on the phone to me straight away".

Shared lives carers were responsive to people's changing needs. For example, one person was supported by their shared lives carers to access healthcare following concerns in relation to their care needs. However, the person's shared lives carers were not satisfied with the outcome of a G.P appointment and responded by asking for a second opinion from a different G.P. The result of this was that the person received the appropriate care and treatment needed in order to improve their quality of life. The staff member that supervised these shared lives carers told us "[Shared lives carers] are very proactive with this sort of thing and they will advocate for [person]. In this case they were not happy with the response from the G.P, so they got another one involved". Another person's care records demonstrated how the person's shared lives carers had constructively challenged a decision by a healthcare professional not to install specialist lifting equipment. The result of this was that the decision was reviewed and the equipment was installed.

People and shared lives carers were carefully 'matched' to ensure people received care from shared lives carers who they felt comfortable with and who were able to meet their care needs. The independent approval panel took into account the 'matching' process when making their decisions. This involved an introduction process that included tea visits, overnight stays and a variety of other meetings between the parties. Shared live carers or the person could decide it was not an appropriate placement at any time. One senior staff member we spoke with told us "With the matching process we can do it slowly or fast depending on people's needs".

Care records contained details of people's medical histories, allergies and on-going conditions. Care plans had been developed from the information people provided during the assessment process. Care plans were updated regularly to ensure the information was accurate.

Shared lives carers we spoke with knew the people they cared for, including their preferences and personal histories. For example, one carer told us about a person's personal history and what was important to them in their social life and local area. This included information about the person's favourite shopping area. This information matched what was written in the person's care records. Another person's carer described the importance of following a person's routine at significant times of the day. This information also matched what was written in the person's care records.

One person had a history of epilepsy. This person had an 'epilepsy care plan' in place which was kept under constant review by the service. The care plan also contained guidance for staff to mitigate harm to this person should they experience a seizure. Records confirmed that there had recently been a change in this person's epilepsy medication. We spoke with this person's shared lives carers who confirmed that they were aware of the change in needs and followed the additional guidance from the persons G.P. We also noted that the shared lives carers had received specialist training for the administration of a medicine which was

to be used in the result of a seizure.

People were provided weekly activities as part of the shared lives agreements. Day time activities varied and included formal day services and activities that allowed people to pursue their own lifestyles independently regardless of their disabilities. Activities were dependent on people's choices, skills and abilities. Support plans included details of when activities took place. This meant that people were supported to avoid social isolation. Staff understood the importance of people receiving meaningful activities.

The service was also responsive to the needs of the shared lives carers. For example, we saw evidence that the service had worked with the shared lives carers of one person, who were also related to the person. The service respected their choices and decisions in relation to the frequency of monitoring visits. The impact of this was that the service was empathetic and responsive to the circumstances and needs of the person and their relatives.

Shared lives carers and relatives knew how to raise concerns and were confident action would be taken. The service's complaints policy was available to all people. Records showed there had been three complaints since our last inspection. These had been resolved to people's satisfaction and in line with the provider's complaints policy. One person we spoke with told us "I haven't made a complaint but I know how to. I feel I would be listened to if I did complain". We noted that complaints and safeguarding concerns were scrutinised by the independent panel to ensure that the scheme took the appropriate action.

The service sought people's and shared lives carers views and opinions through quality 'monitoring visits', 'satisfaction surveys' and 'shared lives carers meetings'. One carer we spoke with told us of how they made a suggestion on shared lives carers being issued with identity cards in order to officially identify them as shared lives carers when they were supporting people in the community. The service acted on this request and introduced identity cards for shared lives carers. The carer explained the positive impact that this made. They told us "Occasionally I used to get questioned on whether I was a carer or not. Now no one questions if I am a carer or not, it makes things easier when we are accessing things in the community. It also promotes ours and the service user's dignity". Another carer told us "We get informed of the meetings, they are quite regular". One relative we spoke with told us "We get asked our opinions, but to be honest I haven't had any because it's all fine we never have any problems".

Good

Is the service well-led?

Our findings

Staff spoke positively about the registered manager. Comments included "[Registered manager] is very open and fair", "[Registered manager] is nice and I find her approachable" and "[Registered manager] is super knowledgeable".

The registered manager told us their visions and values for the service. They told us, "We want the service to be person centred and we are always keen to develop the service in a service user led way". There was a positive and open culture in the office and the registered manager was available and approachable.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One member of staff we spoke with told us "I would have no problem with raising an issue with [registered manager], she would respond quickly".

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the scheme had informed the CQC of reportable events.

Regular audits were conducted to monitor the quality of service. These were carried out by the registered manager and senior practitioners. Audits covered all aspects of care including, care plans, risk assessments, support and monitoring visits, annual reviews, training and the day to day management of the service. Learning from these audits was used to make improvements. For example, following a recent review of the training program for shared lives carers the registered manager decided that there some shortfalls in the content of the training. As a result the registered manger introduced new training that was aligned to a national certificate in care. We spoke with the registered manager about this and they told us "The training was all right but it was not good enough" and "I decided that it did not reflect what we needed".

Staff we spoke with told us that the registered manager was always looking to improve the service. One staff member told us, "She encourages new ideas, and we are always involved in any developments". Another staff member told us, "We have team meetings where we discuss practice issues and things that are working and things that are not". This demonstrated that the service was continually looking to improve.

Accidents and incidents were recorded and investigated. The registered manager used information from the investigations to improve the service. For example, following an incident were a person complained that their dietary requirements were not being met, the registered manager and staff worked in partnership to ensure that this was resolved. This included a review of the person's needs. As a result a comprehensive meal planner was put in place. We spoke with this person's relative and they told us, "They sorted in out straight away". We noted that this incident had been referred to the independent panel. We spoke with the registered manager about this and they told us, "All incidents go to panel, we always investigate incidents".

The service worked in partnership with visiting agencies and had links with GP's, district nurses care managers and occupational therapists. Records of referrals to healthcare professionals were maintained

and any guidance was recorded in people's care records. Throughout our visit the staff we spoke with recognised the need for partnership work. We spoke with the registered manager about this and they told us, "It will only work if we all work together".