CareQuality Commission

Imagine Act And Succeed

Imagine Act and Succeed

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 inspection took place on the 19 and 20 September 2017. We gave the service 24 hours' notice of the inspection to ensure that the managers were available to speak with us. This was the first inspection of Imagine Act and Succeed since it had been re-registered with the Care Quality Commission in June 2016. The re-registration had taken place due to a change in the office address for the service. The service, under its previous registration as IAS 65 Chorley Road, was inspected in May 2015 and was rated good overall.

Imagine Act and Succeed (IAS) is registered to provide personal care in people's own homes. The service supports 55 people through their domiciliary care service, 22 people in an extra care scheme (Fiona Gardens) and 21 people lived in supported living properties, either on their own or sharing with others. The domiciliary care service provided support from one visit per week to multiple visits each day. The extra care scheme provided assessed support for 22 people and an emergency on call service for the remaining 50 flats in the scheme. Some of the supported living houses provided 24 hour support and others a planned schedule of support, depending on the assessed need.

The service had a registered manager in place. 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.

All the people who used the service and their relatives were complimentary about IAS and the support provided. The staff said they enjoyed working for the service and felt very well supported by their service leaders and senior managers.

There were sufficient staff on the rotas to meet people's needs. In the domiciliary care service people said they were supported by regular staff, who were on time and did not miss visits. Relatives said the supported living staff teams were kept as stable and consistent as possible. This meant people were supported by staff who knew them and their support needs well. We were told there was good communication between the staff and people's relatives.

Detailed person centred care plans and risk assessments were in place. These provided guidance and information about people's support needs, their likes, dislikes and preferences and how to mitigate the identified risks. Comprehensive positive behaviour support plans were in place for those people with complex behaviours which may challenge the service.

Each person had a one page profile in place documenting key likes, dislikes and how they wanted to be supported.
A living well document was being introduced, part of which documented people's wishes for their end of life care and support. Some people had completed this; however others did not want to discuss the end of their lives. People living at Fiona Gardens were supported to stay in their flat at the end of their lives if possible.

Additional visits were made as their needs changed.

People and their families were involved in writing and reviewing the care plans and risk assessments. Relatives said they had regular feedback from the staff teams about their loved ones.

People received their medicines as prescribed. A medicines lead role and a new medicines system (called Bio-dose) had been introduced at Fiona Gardens in response to a series of medication errors. This had resulted in a large reduction in the medication errors made. We have made a recommendation that all medicines leads are made aware of the full prescribing instructions for the medicines they administer. Guidelines for when 'as required' medicines were to be administered were in place in the supported living service. At the time of our inspection all the people supported at Fiona Gardens were able to tell staff if they needed an 'as required' medicine. We discussed with the registered manager that 'as required' guidelines would be required if people's needs changed and they were not able to verbally request them.

The service was working within the principles of the Mental Capacity Act (2005). People had decision making tools in place so staff could support them to make decisions about their lives. Communication aids were in place where appropriate to support people to be able to communicate with staff and others.

The service was open and transparent. All incidents and safeguarding referrals were fully investigated and any potential improvements identified were implemented.

Staff received the training appropriate to their role. New staff completed a thorough induction and shadowed experienced staff so they were able to get to know people and their needs. Staff had regular job consultations (supervisions) with their manager to discuss their development and performance. Team meetings were held, which were open discussions. Staff said they felt well supported by their service leaders and senior managers. Staff representatives were involved in a development board with senior managers to discuss new initiatives and changes within the organisation.

Robust staff recruitment procedures were in place. People who used the service were involved in staff recruitment decisions. Staff were matched with the people who used the service so they shared similar interests.

People were supported to maintain their health, with care plans detailing the support they needed. Staff supported people to attend health appointments where required.

IAS sought the views of people who used the service and relatives through tenants meetings, friends and family meetings and surveys.

People were supported to participate in activities within their local community. A programme of regular activities such as a pub night had recently been arranged.

IAS had a complaints policy in place. All complaints received were investigated and outcomes agreed with the complainant.
A range of quality audit tools were in place, including monthly returns from each service leader recording the job consultations and care plan reviews completed. Managers monitoring training requirements through a database which highlighted the training that needed to be refreshed. A new quality team, including people who used the service and relatives, was being established.

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.

Risks were identified and clear guidance for staff to follow was recorded to mitigate and manage the risks.

Safeguarding concerns, incidents and accidents were reported and thoroughly investigated. IAS showed they used the investigations to make any changes and improvements that had been identified.

People received their medicines as prescribed and medicines were safely managed. We have made a recommendation for all staff to know the full prescribing instructions for each medicine they administer.

Sufficient staff were available to meet people's assessed needs. A robust recruitment process was in place.

Is the service effective?

Good

The service was effective.

The service was working within the principles of the Mental Capacity Act (2005). Decision making tools were in place, where required, to guide staff on how they should support people to make their own decisions.

Staff received the training and professional support through job consultations and team meetings to effectively undertake their role.

People were supported to meet their nutritional needs and maintain their health.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in developing and reviewing their care plans.

People said the staff were kind and caring. Staff knew people's likes, dislikes and support needs.

Staff knew how to maintain people's dignity and privacy when providing personal care and prompted people to complete tasks independently.

Is the service responsive?

Good

The service was responsive.

Detailed person centred care plans were in place that provided guidance for staff in how to meet people's needs.

A programme of regular activities for people to take part in had recently been established. People were supported to access leisure opportunities in their local community.

The service had a complaints procedure in place. All complaints received had been responded to appropriately.

Is the service well-led?

Good

The service was well led.

A robust quality assurance system was in place to monitor the service. New quality auditing measures were being introduced to involve people and their relatives.

Staff said they enjoyed working at the service and felt the management team were very supportive and approachable.

IAS invited feedback about the service from people and their relatives through tenants meetings, family and friends meetings and surveys. Staff were involved in development forums and staff meetings.

Care Quality Commission

Imagine Act and Succeed

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 19 and 20 September 2017. We gave the provider 24 hours' notice of the inspection because they are a supported living and domiciliary care provider and we needed to make sure someone would be available to speak with us. The inspection team consisted of two inspectors on both days of the inspection.

The provider completed a Provider Information Return (PIR) prior to our inspection. The PIR 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 reviewed other information that we held about the service including notifications made to the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning and safeguarding teams. Their feedback on the service can be found within this report.
During the inspection we visited, with their permission, two people who had support in their own home, two supported living properties and the extra care service, Fiona Gardens. We spoke with 13 people, seven relatives, the registered manager, three deputy Heads of Operations, two service leaders, one support leader and seven care staff. We looked at records relating to the service. These included 12 care records, three staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, quality assurance systems, incidents and other records relating to the management of the service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe supported by IAS staff and where people did not have 24 hour support they looked forward to the staff visiting them. One person said, "I look forward to them (staff0 coming as I can have a good conversation with them." Another person said, "I feel safe in my home; I know that staff are in the sleep-in flat but I never need to call them. I have an intercom system to let people in."

We found clear and transparent reporting procedures were in place for all safeguarding concerns, accidents and incidents. All incidents had been fully documented, investigated and reported appropriately. Any action taken as a result of the investigation was recorded. Prior to our inspection we had received information from a whistle blower raising their concerns about the support provided to two people. The registered manager and deputy head of operations openly discussed the issues raised and provided detailed information about the support provided. We also spoke to the local authority social services about the issues raised by the whistle blower. They stated that IAS had involved the people's families and other professionals in agreeing the support to be provided. They said IAS had been open and transparent throughout the process. Where improvements had been identified these had been acted upon by the service, for example increasing the handover information provided between staff when they start their shifts.

This meant any incidents were fully investigated and any potential areas for improvement were implemented.

Staff told us, confirmed by the training records, that they had completed training in safeguarding vulnerable people. Staff were able to explain the different types of abuse and the IAS procedures in place for reporting any potential abuse. A support leader told us, "If I see something, such as a bruise, I report it straight away and I'd look at what staff had recorded (in the care files)."

We saw that 'finance clips' had been introduced to increase the security of people's money held by IAS. These consisted of a zipped plastic wallet which was secured with a numbered plastic tag. When money was accessed the plastic tag was replaced and the new number noted in the finance record book. In this way it was possible to track which staff members had handled the money, thereby improving the security of people's money.

We looked at how medicines were managed at the service. We noted that there had been a number of internal investigations surrounding medicine errors over the last 12 months. These had primarily been at the extra care scheme Fiona Gardens. We saw each error had been investigated and appropriate action taken. The registered manager told us IAS had changed the way medicines were managed due to the number of issues that were occurring and the errors had subsequently reduced.

We saw that at Fiona Gardens one staff member per shift was now nominated as the medicines lead for that shift. This meant they concentrated on administering people's medicine with other staff supporting people with their support routines. We also noted that the 'Biodose' monitored dosage system had been introduced. The Biodose system can contain both liquids and tablets. All the medicines required at one time

are sealed in a pot by the pharmacist, with the person's name, tablet name and dosage printed on the pot. This meant people were protected from risk of harm as the staff were easily able to check they were administering the correct medication at the correct time.

The staff we spoke with said they found the Biodose system a lot easier to manage and were positive about the new medicines lead role. They said that it meant they were not disturbed when they were administering medicines and so made fewer mistakes. The staff also said that now one pharmacist provided everyone's medicines it was easier to contact the pharmacy if required. One staff member said, "It's so much easier now with the Biodose system" and other told us, "The medicine lead works better as you've got more time now and don't get distracted." We saw that there had been fewer medicines errors made since the new system had been introduced.

This meant the service had identified an issue with the medicine administration at Fiona Gardens and found a solution to reduce the likelihood of medicine errors occurring.

In the supported living services, domiciliary care services and at Fiona Gardens we saw the medicine administration records (MARs) had been fully completed. Everyone we spoke with said they received their medicines at the correct time. Medicines within the supported tenancies and people's homes were kept securely. People's care plans outlined, if required, the exact support they needed to take their medicines safely.
Staff were clear on the level of support each person required and were able to describe how they would report any concerns. There were policies and procedures in place for the ordering, receipt, storage, administration and disposal of medication. Any allergies to medicines were clearly identified and recorded on the MAR and in people's care plans.

In the supported living properties, staff were responsible for checking the medicines at the start and end of each shift to assure themselves there were no discrepancies. This meant that any errors would be identified quickly.

In the supported living houses and domiciliary care services service, there were clear guidelines as to when any 'as required' medicines, such as pain relief or to reduce anxiety, were to be administered. This included a visual 'pain recognition tool' to assist people who were non-verbal to express if they were in pain.

We were told that currently all the people at Fiona Gardens who needed 'as required' medicines were able to inform the member of staff of this. We discussed with the registered manager and service leader that 'as required' medicines guidelines would be required if people's needs changed and they were no longer able to verbally communicate that they needed an 'as required' medicine to be administered.

Some medicines need to be administered at least 30 minutes before food was eaten. We noted from the rotas at Fiona Gardens that the medicines lead visited one person to administer their medicine before another staff member went to support them to get up and have their breakfast. This meant the service had managed the rotas to ensure that sufficient time had elapsed after the person had taken their medicines before they ate their breakfast. However we found that the medicines lead on the day of our inspection was not aware of the requirement to ensure there was a 30 minute gap between taking the medicine and eating food. We recommend that best practice guidelines are followed to ensure each medicine lead staff member is made aware of any particular prescribing instructions for the medicines they administer.
Records showed that medicines training was refreshed annually and service leaders observed staff competency to administer medicines. The service leaders at Fiona Gardens and the supported living schemes audited the MAR sheets each month. In the domiciliary care service MAR sheet audit were

completed every six months.

This meant people received their medicines as prescribed and checks were in place to identify any errors. Appropriate action was taken when errors had been identified.

IAS had completed a management re-structure in early 2017. This introduced a service leader position and the larger teams also had support leaders. From the rotas we saw there were sufficient staff on duty to meet people's agreed support needs.

People and relatives told us that the domiciliary care staff and the Fiona Gardens staff attended for each agreed call and they had regular staff supporting them.

The domiciliary care agency service had nominated core staff to support each person. This included additional staff who knew the person who were able to cover for annual leave or sickness. We saw that staff had time on their rota to travel between calls, which meant they were less likely to be late for their support visits.

One person at the extra care scheme told us, "They (staff) come quickly if I pull the (emergency) cord." People said they received a rota in advance so that they knew who was going to be supporting them. One person said, "Staff arrive when they should do, I get a rota every Saturday" and a relative told us, "I asked for the rota to be sent to me and now they are emailed to me so I know who will be supporting [name]."

Relatives of people in the supported living houses said that IAS tried to maintain a stable staff team supporting their loved ones. One relative said, "They (IAS) keep staff as stable as they can; it's not a procession of strangers." Another relative told us, "They (IAS) do always get cover (for a support shift), but the staff do keep changing." We spoke with the registered manager about staff recruitment and they acknowledged that it was an ongoing exercise to recruit suitable staff. They told us that IAS did not use agency staff, with cover being arranged from within the staff team wherever possible or from other teams. If required the service leaders would cover shifts. This meant that people were always supported by IAS staff.

We looked at three staff personnel files. All files had the required pre-employment checks in place, which included two references, proof of identity, full employment history and a Disclosure and Barring Service (DBS) check. The DBS check helps to ensure that the person is suitable to work with vulnerable people.

The service completed two interviews to ensure potential employees were suitable for the service. An initial structured interview was completed followed by a supervised visit to meet people who used the service. This was used to identify potential matches for the person with employees with similar interests. The 'Matching Staff' tool asked what people did and didn't want from their support staff. We saw that people were able to say they did not think the applicant was suitable to support them and the service listened to this and did not employ the applicant. This meant that robust systems were in place for the safe recruitment of staff with meaningful involvement of the people who used the service.

We looked at how risks were managed by the service. In each person's care file we saw an assessment of the risks had been completed which gave clear guidance for staff in how to mitigate the identified risks. These included bathing, accessing the community, moving and handling (if appropriate), food and drink (risk of choking) and safety around the person's home.

For people who did not have staff support all the time there was a 'health and safety assessment for people living with minimum support or people who spend time at home without staff support' in place. This was a

comprehensive person centred assessment of the risks the person needed to be aware of when they are on their own and how the staff team will support them to stay safe. Areas covered in this document included fire safety, gas and electrical safety, security of the home, the use of cleaning products and kitchen safety. It provided details of how the staff should remind people about the risks and how to mitigate them. Assistive technology, such as door sensors, was used where assessed as being required. These would alert the duty manager if a person had left their home without staff support so that staff could then contact the person or go and support them. People's relationships with their neighbours were also noted, with IAS providing a contact number for the neighbours to use if they had any concerns, if appropriate.

People and their relatives confirmed with us that they had been involved in developing their risk assessments. This meant that a robust risk assessment process was in place which respected people's rights and choices and enabled people to be as independent as possible through positive risk taking, for example spending time at home on their own.

Some people supported by IAS had complex behaviours which may challenge the service. Where appropriate positive behavioural support plans (PBSP) had been developed by the IAS behavioural support team or in conjunction with the local authority community learning disability teams. The PBSP identified an individual's 'baseline' behaviour and how this changed if they became anxious or agitated. Potential triggers for people's anxiety were recorded. Clear guidance for staff was provided in how to de-escalate a potential situation, with examples being given. If de-escalation techniques were not successful the breakaway and defensive techniques to be used by staff were recorded. This meant staff had clear information about the potential behaviours, their triggers and how to manage the potential behaviour. This should help to keep the person and staff safe when they become anxious or agitated.

Staff told us that they completed regular health and safety checks while visiting people's homes. These included a visual check of any fire alarms and smoke detectors and checking that there are no hazards within the environment. They also checked water temperatures before supporting people to bathe or assisting them to wash.

Staff who were lone working were advised to download an app to their phone which could be programmed to contact a person of their choice if they felt they were in danger. By shaking their phone, the app alerts the chosen person that the staff member might be in danger. Staff are also provided with personal protective alarms to assist with keeping them safe.

Good

Is the service effective?

Our findings

People and their relatives were complimentary about the support they received and felt the IAS staff had the appropriate skills and knowledge required. One relative said, "The staff are well trained to meet [name's] needs." Most relatives said that they were kept well informed by the staff team supporting their loved one about what they had been doing and any changes in their health and wellbeing. One relative said, "The staff will send me photos of what [name] is doing which I really like." However one relative we spoke with said they would like more communication from the staff team about what their loved one had been doing.

Staff told us, confirmed by the training records, that they completed three days of training as part of their induction with IAS. This included the IAS values, person centred planning, moving and handling, health and safety, first aid and safeguarding. All new staff completed an induction handbook over a period of their 12 month probationary period. The handbook covered all elements of the nationally recognised care certificate. The care certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. All staff were enrolled on a nationally recognised level 2 qualification in health and social care within their 12 month probationary period.

Staff and service leaders told us that new staff shadowed existing staff for two weeks as supernumerary to the rota. This meant they were able to get to know people and their support needs. At Fiona Gardens night staff then also shadowed two night shifts so they were aware of the night time routines.

We saw that staff attended annual 'cascade' days for refreshing their training. These days were led by IAS facilitators and covered safeguarding, health and safety and food hygiene. Training was provided to staff teams so they were able to meet the specific needs of the people they supported. For example one relative told us, "The staff went on an autism course and another course about bi-polar (disorder)." We saw training in breakaway techniques was completed where staff supported people who may have challenging behaviour. The majority of the staff at the Fiona Gardens extra care scheme had completed a dementia awareness course. One staff member told us, "I've done specific dementia and epilepsy training so I can meet the needs of the people I support."

All the staff we spoke with said they felt they received the training they needed for their role. The deputy head of Operations showed us a matrix recording all the training completed by each member of staff and when a refresher course was due. They then requested the training courses that the staff needed through the IAS head office. A support leader told us, "I get an email from head office when staff need refresher training and the date of the course so I can put it on the staff rotas."

New development handbooks had been introduced to support the new support and service leaders in their new roles. These recorded both formal and informal learning opportunities, for example reflections on leading team meetings or completing job consultations (1:1 supervisions).
All the staff members we spoke with said they were well supported by the service leaders and senior managers. They said they had regular job consultations and were able to approach their manager at any

time. The job consultations took place every six weeks and were used to discuss the staff member's role, any concerns they had and any training they needed.

This meant the staff received the training and support to be able to effectively meet people's assessed needs.

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 people lack the 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community settings are through the Court of Protection. We checked whether the service was working within the principles of the MCA.

We saw people's care files contained information about how they made decisions and the support they needed from staff in order to be able to do this. A decision making tool was in place where required. This detailed the type of decision to be made, for example what I eat, where I go, taking medicines, dealing with money and finances. Information was provided about how the person was to be supported to be involved in the decisions and who else was involved in the decision, for example the GP in the case of medicines. Another care file noted the person had capacity to make the day to day decisions, but a formal capacity assessment would be required for 'big' decisions, for example moving home.

Where the person was assessed by IAS as not having capacity to make decisions about their care a referral was made to the local authority for a formal capacity assessment to be completed. The local authority would then submit any applications to the Court of Protection as required. At the time of our inspection there was some confusion on the paperwork the local authority wanted these referrals to be made on. People's capacity to make decisions was reviewed each year as part of the IAS annual reviews. Any changes were highlighted to the local authority at the review meeting.

The registered manager was aware that the use of assistive technology, for example to monitor if people left their homes, constituted potential restrictive practice. Where this type of assistive technology was used appropriate referrals were being made to the local authority for authorisation.

Staff we spoke with understood the main principles of the MCA and were able to explain how they gave people choices and involved them in decisions about their care and support. One said, "I always show people what options are available, for example their meal, so they can choose what they want."

In the extra care scheme where staff supported people with their meals we saw this was clearly documented in the care files. For example, one person ate at the on-site restaurant three times each week. A menu planner had been written which reminded staff of the days they needed to ask the person which frozen meal they wanted to be taken out of the freezer and when this was not required. One person told us, "The food's good. I can choose the food I want and we arrange a menu."

In the supported living properties and domiciliary care service people were supported to prepare meals where this was required. One person told us, "We do cooking together on a Friday, they listen to me and we have brews together."

People's care plans detailed the support people needed to eat and drink. Where required 'thickeners' were added as prescribed to fluids to reduce the risk of the person choking. This meant people's nutritional needs were being met.

We saw people's care plans contained details of the support they required to maintain their health. The support a person would need if they had to go to hospital had been identified and hospital passports completed. Hospital passports provide brief information about the person, how they communicate and their needs for the hospital staff. Each person also had an emergency grab sheet as a quick reference guide for those who needed to access help in an emergency.

Relatives told us how staff supported their loved one to health appointments. The relatives said the staff would contact them if the person they were supporting was unwell. One relative told us, "The staff supported [name] to a medical appointment. They immediately said they would swap their shifts so they could support him for the next appointment as well to keep continuity. This is typical of what they do."

Clear guidelines were in place for staff to support people with monitoring blood sugar levels for those people who were diabetic and for people who required more complex medication. This meant people were supported to maintain their health.

Good

Is the service caring?

Our findings

People and their relatives spoke warmly about the IAS staff. One person said, "The staff are lovely; they look after us very well" and another told us, "My staff are very caring, they are kind and let me do what I want to do." A relative told us, "[Name] is really pleased; she loves the staff" and another said, "They (the staff) are always friendly and helpful and go the extra mile."

People we spoke with said they were involved in planning their care. People were supported in a variety of ways to communicate their wishes and needs to the staff team. These included communication dictionaries and decision making tools providing guidance on the support people required to make decisions about their lives and support.

All the relatives we spoke with said that IAS involved them in agreeing their loved ones care and support plans. One relative said, "We're very involved in reviewing the care plans. We meet any new staff before they support [name] and have a mobile phone number for each member of staff in the team. We encourage staff to phone us if they are unsure about anything."

Relatives felt listened to by IAS. One said, "I let them (IAS) know if [name] isn't happy and they will make changes to the support." Others told us, "They are open and I can say what I want," and "I get asked if they can do anymore to support [name]."

The service also held regular family forum meetings. These were open forums and were used to gain feedback from relatives and friends as well as provide information about the service, for example new initiatives to increase social opportunities or staff recruitment.

This meant IAS involved the people they supported and their relatives in agreeing the care and support to be provided, were open to concerns and ideas raised with them and sought feedback on any changes people wanted to their support.

Staff we spoke with knew the people they supported and their needs well. Each person had a one page profile in place which provided brief information about what was important to the person and how staff could best support them. They were able to describe to us people's needs and how they maintained people's privacy and dignity when providing support. One staff member said, "I always talk to people about what I'm doing and ask if they want to do something or if they want me to do it."

People's care plans contained detailed information about their likes, dislikes and preferences, for example for activities or food they wanted. We saw one care plan described how a person liked their bath (warm with lots of bubbles) and another how the person became distressed if a professional person wearing a uniform visited. Staff had liaised with professionals visiting the person to ask if they could wear casual clothes on visits to this person.

The care plans clearly identified the tasks people were able to complete themselves and where they

required staff prompts or support. One care plan stated 'I am very independent and capable; please remember this and don't try to do too much for me.' This meant that people were encouraged to maintain their skills and independence.

IAS's philosophy of providing 'just enough support' meant that people had the support they required, but also had time on their own where this was assessed as being safe. Assistive technology was used to enable people to have more independence. For example, sensors were used to alert staff if people had left their homes and fall sensors informed staff if someone had had a fall. This meant that people did not need to have staff with them at all times and provided them with their own space and independence.

One relative said, "[Name's] achieved more than we thought was possible. He's learnt more skills and is a person in his own right; he has a future." A comment made in a letter to the service stated, 'I have met five carers; I have been well impressed with the work they do, they have been very communicative with [name] and me.'

People's diversity and cultural needs were clearly captured in the care planning documentation. This included any preference the person had for female or male staff members. This meant staff had the information they required to be able to meet people's individual support needs. For example we saw that some people were supported to attend church each week. A relative told us, "Staff take [name] to church on Sunday mornings; this is important to [name] and us as her family."

Some people had discussed and recorded their wishes for the end of their life. This had been recorded in the second section of a 'Living Well' booklet, which included details of the person's wishes if they were poorly or at the end of their life and who they wanted to be involved in any discussions about their care at the end of their life. It also detailed how they wanted to be remembered after their death. We were told that 20% of people supported by IAS had discussed and recorded their end of live wishes; however some people did not want to talk about the end of their life.

People living at Fiona Gardens extra care scheme did not have their end of life wishes recorded in their care files. We were told and saw that a new customer journey assessment tool was in the process of being introduced at Fiona Gardens. We saw this was based on the Living Well booklet. As the customer journey assessment was introduced people would be encouraged to discuss their end of life wishes. All new referrals were now using the customer journey assessment tool, with existing people's care and support plans changing to this format at their next annual review.

Staff we spoke with at Fiona Gardens told us how they tried to support people as long as possible in their flat at the end of their life, if that is what they wanted. Local community health services such as district nurses and GP's would advise on the support a person needed. We saw one person was currently having additional calls from staff as they were coming to the end of their life, but did not want to move to a residential home. The staff we spoke with knew the purpose of the additional visits was to ensure the person was comfortable and prompt them to have a drink. The service lead said they would continue to be guided by the GP on the person's care needs and request a re-assessment of need from the local authority if the person required additional support.

Good

Is the service responsive?

Our findings

We saw each person had a detailed person centred care plan in place. This provided staff with clear information about a person's abilities and support needs and covered communication, family and friends, culture and faith, weekly and daily routines, risks, personal care, dietary requirements, health, managing their own home and finances.

The care plans included clear guidance for staff in how to meet people's needs and also what people were able to do for themselves. The care plans had been regularly reviewed with the person and their relatives, if applicable. Reviews looked at what was working well and whether there were any areas that could be changed and improved. We saw people had agreed goals they would like to achieve in the future, with a named person who would be responsible to support them to work towards their goals. Where IAS supported people to manage their money a financial review was part of the annual review process. This established an outline budget for each week, taking into account the activities a person wanted to do and the things they wanted to buy.

People and their relatives told us that they were involved in reviewing their care and support. One relative said, "We have annual reviews; they (IAS) will listen to my ideas and I can say what I want to" and another told us, "Yes I'm involved in reviewing [name's] care and support. It is open and honest." Relatives said they were also kept informed by staff about the activities they were doing or if there was any changes in their loved ones health. One relative said, "I get good feedback on things that have happened to see if I have any ideas on how to deal with it the next time" and another told us, "Yes the staff let me know about what's happening." However one relative told us that the staff did not always keep them informed about what their loved one had been doing.

A service lead told us that head office kept a data base of when all the care and support plans had been written. From this date each care plan was given a red/amber/green (RAG) rating. Red signified if the plan required to be reviewed, amber if it was coming up to the review date and green was within date. This meant that the service leads were aware of what documents needed to be reviewed in advance so that review meetings could be arranged in a timely manner. We were also told that plans would be reviewed sooner if people's needs changed.

Staff told us that they were provided with a verbal handover of peoples' needs when they started to receive support. The care plans were also available for them to read prior to the support starting.

Staff told us that there are clear lines of communication at the service. A communication book was used in the supported tenancies and handovers at the start of every shift completed. This meant staff had clear up to date information and guidance on any changes in people's support needs, health or wellbeing. A 'My Day Tool' was used to document what people had done during their support. This included identifying what had or had not gone well, what people had to eat and drink and activities they had taken part in. These documents were reviewed quarterly by service leaders to ensure that any relevant information could be added to people's care plans.

As previously mentioned in this report, a new 'customer journey' assessment tool was in the process of being introduced at the two extra care schemes managed by IAS, including Fiona Gardens. The 'customer journey' had been developed as a personalised process for people when they first started receiving support, were settling into their support, reviewing ongoing support and advanced planning for people's end of life wishes. The tool focused on what mattered to people, their relationships and how they wanted to be supported by the staff team. Outcomes were recorded for the commissioned service, for example maintaining health or mobility and also wellbeing outcomes. These could be activities people wanted to take part in or places they wanted to visit. The assessment prompted the assessor to consider assistive technology and if there was any informal support available through people's family or local community.

The service leader at Fiona Gardens was becoming involved in completing the new customer journey assessments. Guidance and prompts were being written to help staff to have conversations about people's wishes and needs.

Where people's needs changed referrals to the local authority were made to arrange a re-assessment of the person's care and support needs. We saw that at the extra care scheme people were able to choose a different care agency to IAS to provide their support if they wanted to.

We saw that 'action books' had been introduced to the supported living properties. These compiled, in one place, any actions the staff team had to complete, for example from care plan or risk assessment reviews and health appointments. This meant that any actions were clearly identified and the staff would not lose sight of what had been agreed. The deputy head of operations said that this made it easier to keep track of what staff needed to work on to support people to meet their agreed goals.

A procedure was in place for assessing and agreeing any new person referred to IAS. This included making an initial decision as to whether IAS were able to meet the person's needs from information provided by the local authority. IAS would then meet the person, their relatives, if appropriate and any other people previously involved in the person's care, for example staff at their current placement or health professionals. An initial one page profile, care plans and risk assessments were written. Where possible the person was invited to visit their new home and meet the staff team prior to moving in. This meant the person and their relatives were involved in agreeing the care and support to be provided and the staff had the initial information they needed to support the person when the support started. The service leader would then develop the care plans and risk assessments further as the person settled in and staff got to know them better.

Staff at Fiona Gardens and in the domiciliary care service told us they were always introduced to any new person they would be supporting before the support started. One person confirmed this and said, "New staff are brought round to be introduced before they start to support me."

Following an audit of what people had requested at their annual reviews IAS seconded one member of care staff to establish activity sessions for people to attend if they wanted to. We saw a timetable had been established using one of the community rooms at Fiona Gardens for art and craft and a healthy living club. A monthly cinema trip and pub night had recently started. We saw from minutes of a tenants meeting that people were being encouraged to attend the activities and share staff support where possible.

The staff member had now returned to their substantive duties but the service had plans to keep developing further leisure opportunities for the people they supported. This included community circles where an external facilitator brings together the person with their families, friends and neighbours. The community circle would look at what community support is available for people to enable them to be more involved

with their local community without always relying on paid staff support.

We also saw that the staff at Fiona Gardens had started to organise monthly karaoke evenings and sing a long sessions. These were open to anyone living at Fiona Gardens, not just the people supported by IAS.

This meant the service had recognised that the people they supported wanted more leisure opportunities and had supported one staff member to set up group activities which now took place on a regular timetable.

One person told us, "I started to go and look after horses as my carer had a horse. Now I walk dogs for my neighbours, my carer supported me to do this, I enjoy doing this". Another person told us that they had been supported to get a job locally and their carer had supported them with the application and recruitment process. This meant people were supported to take part in and try different leisure opportunities in their local community.

We saw IAS had a complaints policy in place. All complaints received were recorded, investigated and a reply sent to the complainant at the conclusion of the investigation. The complaints had been dealt with in a timely manner and satisfactory outcomes had been agreed with all parties. This meant that complaints made about the service were acted upon.

All relatives also said they were able to phone IAS directly if they had any concerns and that the staff responding appropriately. We were told, "If I have any issues I phone up and they are very helpful" and "IAS are approachable if I have a concern." This meant that concerns were dealt with proactively when they were raised and therefore did not become a formal complaint.

Good

Is the service well-led?

Our findings

There was a registered manager in post as required by IAS's registration with the Care Quality Commission (CQC). At the time of our inspection the registered manager was, for part of each week, assisting another IAS service who were developing an extra care scheme in their area. The registered manager continued to have overall responsibility for the service and was being supported by the deputy head of operations.

The registered manager was supported by three deputy heads of operations. Each deputy head of operations had responsible for named services, for example Fiona Gardens, supported living properties or the domiciliary care agency. Service leaders managed the individual services and staff teams. Large properties such as Fiona Gardens also had a support leader to assist the service leader. The support leaders continued to work some shifts and also had some time each week for 'management' tasks such as organising the rota.

There were clear lines of responsibility within the service and all the senior managers were involved in the running of the services and knew the people IAS supported and the staff teams.

All the staff members we spoke with were positive about working for IAS. They said, "I really enjoy it; the team we've got, what IAS's aims are – always being person centred and involving people's families", "We've got such a good team here; we've got the duty phone so we can always call someone" and "I feel well supported by the managers, they are a credit and if we need any help, they are there." Staff told us that they never had a problem if they needed to ring the on call out of hours service; the managers themselves were available to cover and support the service to continue to run in an emergency.

Feedback we received from other professionals, for example local authority social workers, was positive, confirming that IAS were open, transparent, person centred and involved people and their families in decisions about the care provided.

IAS ensured that people and staff were involved in providing feedback and developing the service. This was done in a variety of ways including regular tenants' forums, family and friends meetings, team meetings and reviews. There was a clear emphasis on continually improving and developing the service. This included a 'working together for change' workshop involving people who used the service, staff, families and local authority commissioners. Information from people's latest reviews about what was working and was not working was discussed and grouped into themes. Decisions were then made on how IAS would try to address the common areas identified as not working. As a result additional resources were made available to establish more social activities as described earlier in this report.

We also saw questionnaires were used to gain feedback from people's relatives. One relative told us, "I've recently filled in a questionnaire. They asked if there is anything they can do differently or add to the support [name] has." The questionnaires we saw were positive about IAS and the support they provided. Comments included 'Staff always listen to any suggestions and advice' and 'staff at [property name] always strive to provide support and lifestyle choices which is individual to [name's] personality.'

Partnerships with the local housing association and local authority had been formed. This had resulted in a 'good neighbour' scheme being set up. This was where 12 flats had been developed by the housing association with six being allocated for people with assessed support needs and six for other tenants who were 'good neighbours.' The other tenants were interviewed by the housing association prior to be given a tenancy at the flats and agreed they would 'look out for' people and liaise with IAS if they had any concerns. This meant the service was working with other organisations to develop innovative services to meet people's needs.

One staff member told us they were part of the staff development forum. At this three monthly meeting staff representatives from across the IAS services met with the senior managers to discuss issues affecting the staff, for example policies, the recent restructure and terms and conditions. We saw that staff had access to occupational health services to assess if any reasonable adjustments to their work place or shift patterns were required on their return to work following illness. An employee assistance confidential telephone help line was also available which offered counselling and advice such as financial or legal. This meant the provider had systems in place to support their staffs' wellbeing.

All the staff we spoke with said that regular team meetings were held. The minutes we saw showed these were open forums where staff were encouraged to contribute their ideas and discuss any concerns they had. People's support needs were also discussed and any actions to be completed documented. One staff said, "Staff bring up ideas, concerns and we discuss activities we can arrange" and another said, "We can add items to the agenda before the meeting and our suggestions are taken on board."

IAS used a range of quality assurance tools to monitor and improve the quality of the service they provided. Service leaders completed a 'monthly return' detailing the number of job consultations completed, team meetings held and care plans and risk assessments updated. The registered manager and deputy head of operations were able to track staff training and whether care plans were up to date through the use of databases. Service leaders audited the medicine administration records (MARs). We saw that any issues found had been reported, investigated and any lessons learnt implemented.

Quarterly, companywide, health and safety meetings were held to review all accidents, incidents and any other safety issue that had been identified.

We were told that a new quality team was being established which included people who used the service, family members and care staff. We saw minutes from the latest family forum asking for volunteers for this team. A meeting had been held with the prospective team members to agree how the quality team would work.

This meant a system of audits and quality assurance was in place to monitor the service. New quality monitoring tools were being introduced to further involve people and their relatives in the monitoring of the service and drive improvements.

We checked the notifications that we had received from the service for safeguarding incidents, deaths and serious injuries, all of which the service is legally required to report to CQC. They correlated with the records we saw at the home. This meant that the home was reporting to CQC in line with the requirements of the Regulations.