Providence Row Housing Association

Edward Gibbons House

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 25 January 2018 and 1 and 5 February 2018. At our last inspection we rated the service Good overall and Outstanding in Responsive. At this inspection we found the evidence continued to support and improve the rating to Outstanding overall.

Edward Gibbons House is a 35 bed supported living service that provides care and support for men with health issues linked to drugs or alcohol misuse. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of the inspection there were 29 people using the service.

People told us they felt safe and comfortable using the service. Staff attended safeguarding meetings and were skilled in recognising and reporting signs of abuse. Robust risk assessments were in place to mitigate the risks to people's safety and risk management plans were co-produced with people. Policies and practices were reviewed when things went wrong to promote the safety of the people who used the service. Infection control guidelines were followed to minimise the risk to people's health.

The provider continued to provide outstanding responsive care since the last inspection and had taken further steps to build on this. People were valued, appreciated and made to feel part of a community. Care plans were personalised to map people's journey through recovery. The provider had developed tools to guide staff on how to provide person centred care to best support people with their lifestyles and circumstances. The provider worked with other provider's to improve standards of care that were fundamental to enhance people's lives. Discussions were held with people about their end of life needs. People knew how to make a complaint and these were acted on and resolved satisfactorily.

The service was exceptionally well-led. The provider fought for people's rights despite the challenges they faced to influence policy and decision making. The provider created and implemented new pathways of care and adopted new ways of working to reduce the risk of homelessness. Staff were highly skilled and worked collaboratively as a team and successes were shared and celebrated. Surveys were undertaken to monitor and improve the delivery of care to benchmark best practice.

The registered provider was skilled in obtaining people's consent to care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the provider had adapted their policies and systems in the service to support this practice and ensure people were fully supported to make their own decisions wherever possible.

Robust background checks were carried out before staff commenced employment and there was a sufficient number of staff to meet people's needs. Specialised training was completed by staff to make certain they could meet people's individual needs. Staff received the support they required and were supported with clinical supervision to discuss how they could effectively manage people's needs.

People received sufficient food and drink to meet their dietary requirements. Medicines were given to people as prescribed and these were stored safely to maintain their effectiveness. People had access to a wide range of medical and social care professionals to offer advice and treatment to support their on-going health needs. Refurbishments were being made to the premises to include facilities that would be beneficial to people and the wider community.

People told us they were supported by a caring and compassionate staff team. People were involved in the decisions that affected them and staff were empathetic and knew their needs well. Positive relationships were encouraged and staff supported people to maintain these. Services were available so people could have their voice heard by an independent advocate.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Outstanding ☆

The service remains Outstanding.

Is the service well-led?

Outstanding ☆

The service was exceptionally Well-led.

The provider promoted an open, transparent and positive culture. People and health professionals spoke in high regard about the management of the service and what had been achieved.

People were at the heart of shaping the way the service was delivered to drive quality improvement.

The registered provider championed people's rights and worked with key organisations to achieve exceptional results.

Staff were motivated and proud of the service and had a strong organisational commitment in the provider's ethos and values.

Systems of audits were operated and thorough quality checks were in place to improve the standards of care.

Edward Gibbons House

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 25 January and 1 and 5 February 2018. The inspection was unannounced on the first day; we informed the provider we would be returning over the further two days. The inspection team consisted of a specialist professional advisor who was a nurse and an expert by experience on the first day and one inspector on all three days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the last inspection report and notifications sent to the CQC by the provider. Notifications provide us with information about changes to the service and any significant concerns.

During our visit we spoke with four people and spent time observing the care and support people received. We reviewed eight people's care records. We checked five people's medicines charts, staff rotas, health and safety checks, and minutes of meetings, audits and key procedures relating to the management of the service. We observed a staff handover and spoke with four substance misuse workers, the deputy manager, the assistant director of client services and the registered manager. We also visited the head office and spoke with the senior human resources advisor and reviewed six staff recruitment files and training records.

We spoke with two GPs who were visiting the service and following the inspection, we contacted two representatives of the local authority in the London borough of Tower Hamlets to obtain further information about the service.

Good

Is the service safe?

Our findings

People told us the reasons why they felt safe in the home. One person said, "I do feel safe because I know everyone here," and another person commented, "I feel safe, it's a nice comfortable environment." They had an understanding of the service and one person explained that they felt safe because staff would communicate with them if they were late for appointments or had not checked in with staff when arriving back from their walks and visits.

Staff were skilled on how to recognise when people were at the risk of abuse and report unsafe practice. They empowered people to understand what safeguarding meant and the systems and polices in place supported this. When people began using the service they were given an introduction and questionnaires to help them understand what safeguarding was and how to protect themselves and others from abuse. Information about safeguarding was reinforced during meetings with people to communicate the providers safeguarding messages effectively.

A member of staff was a regular attendee at the local authority safeguarding adult board meetings and shared updates about safeguarding matters with the staff team. Where people were at the risk of abuse the provider had worked in partnership with the placing authority to investigate the concerns and apply a clear action plan to protect people from harm.

Robust multi-agency risk assessments contained specific guidance to reduce the likelihood of risks to people's health, welfare and safety. Regular welfare checks were carried out in the home for people with high support needs or behavioural risk. There was evidence of joint working with the emergency services, such as the police, probation services and local healthcare services to mitigate risk and plans of action were followed. Systems and processes were reviewed when risks to other people's safety escalated. For instance, the records we looked at showed the weapons policy was updated when potentially dangerous items were found during a room check. Notices were displayed in the home to warn people about the dangers of new drugs such as Spice and what they should do in the event of using this.

Risk 'voluntary' agreements were co-produced with people for the purpose of supporting them and to help them manage risk. There were daily agreements written by people and staff to show how they wanted staff to maintain their safety to prevent the risk of financial, physical and verbal abuse. This was done with full transparency as people had consented to their risk plan and could withdraw from the agreement when they chose. This ensured that people were involved in the decisions as much as possible so they were supported to stay safe whilst respecting their wishes.

We were informed by the registered manager that there were two staff vacancies. Rotas demonstrated that when the provider needed to cover additional staffing hours, locum workers were sourced. We observed there was enough staff working in the service to meet people's needs safely and people and the staff we spoke with confirmed this.

We visited the provider's head office and spoke with the senior human resources advisor to check the

recruitment procedures. They explained the provider recruited staff locally where possible and told us how they advertised their posts. Robust pre-employment checks were carried out before staff were employed. Staff personnel records included competency assessments, verified references and right to work in the UK checks. The advisor told us, "If someone has a visa we use the employer checking service, as long as we get their written consent. We diarise when visas are due to expire." Criminal record checks were undertaken so the provider could make informed and safe recruitment decisions.

At the time of the inspection five people were supported with their medicines and we found the relevant guidance about the safe management of medicines was followed. Clear information was recorded about people's medicines along with the details of the medical professionals involved in their care. Medicine administration records were satisfactorily completed and corresponded with the medicines given in blister packs; indicating that people had received their prescribed medicines at the right time. People's medicines were stored securely at the safe recommended temperature.

Clear infection control and prevention guidelines were in place and these were followed by staff. People had access to services that provided needle exchange. There was a needle disposal system to encourage greater awareness for people's health and safety when they used potentially dangerous sharps. We saw records to evidence that some staff had completed training on the removal of body fluids and sharps. This helped to safely protect people and staff from acquiring infections and prevent cross-infection.

People had fire evacuation plans in place to show how they should evacuate the building safely. The fire alarm sounded during the inspection and there was evidence of staff knowing the unit procedure, they all communicated and reassured people and quickly established that it was a false alarm. Staff reset the fire panel and we saw that people responded appropriately during the false alarm as if it was a real emergency.

Staff spoke about the strategies they followed to monitor incidents and accidents that occurred. There was a room in the service that people could access to give them a safe space to drink alcohol with designated opening hours. This was to allow people to drink in a safe area in the service instead of somewhere they may be vulnerable to abuse in the local community. Staff identified the instances the use of the wet room had resulted in physical and verbal conflict between people and of trips and falls. This led to the registered manager reviewing the opening hours of the room in consultation with people using the service and an agreement had been reached to reduce the times people could access the room. This resulted in a reduction of incidents and accidents due to earlier closing times. This demonstrated that people were involved in the running of the service and that lessons were learnt when things went wrong.

Good

Is the service effective?

Our findings

People told us that staff had been trained to help them in the way they wished to be supported. Staff told us the management team were supportive and were available when they needed. They said they were helped to develop their skills, knowledge and practice. Records showed that staff supervision and appraisal arrangements were in place, but for two members of staff we found there were some gaps in their appraisals. However other records showed they had been effectively supported through regular supervision and staff meetings. We pointed this out to the registered manager who agreed to update the appraisals for two members of staff.

We reviewed the staff training records that were held at the head office. When staff first began work at the service it was vital that within one week of employment they signed a checklist to confirm they had read and understood the provider's most important policies. This included the fire procedure, violence at work policy, HIV and aids and hepatitis B, alcohol misuse and the reporting of serious incidents in the workplace. The records we looked at confirmed this was done. Training certificates evidenced that staff had attended various forums and completed a wide variety of essential training. The topics included behaviour that challenged, safeguarding, medicines, complex trauma, drug and alcohol misuse, motivational interviewing, first aid at work, multi-agency risk assessing and customer service training.

Essential training was completed by the staff team and this was led by health and social care professionals. For example, a safeguarding lead from the local authority gave staff training on safeguarding. In addition to this, staff received training on blood borne viruses from the drug and alcohol action team.

Staff told us the training was good and looked forward to receiving more in-depth training on effectively managing people's behaviour that challenged the service. The registered manager told us that staff had established what training they would like as a team. As a group they had arranged for a well-known medical practitioner who specialised in unique and original training for staff in personal safety and crisis mental health to support them in their role. This was to enhance the team's expertise. They explained that after the training they would be going out for a meal which was an important part of developing team relationships.

The provider used a person centred approach called Outcomes Star which is an evidence-based tool for measuring and supporting change when working with people. Supplementary information showed that the provider had co-produced plans with people to help them achieve their intended goals. For example, plans were in place to support people to consume lower strength alcohol and engage with alcohol services to decrease their dependency. A second person's notes showed that they would like a role helping in the service and they were supported to tidy areas of the communal rooms to make the environment more inviting for people. A third person was managing their addiction but had found this increasingly difficult, due to the influence of others and living within close proximity of another person who misused substances. It was agreed that it was in the person's best interests to move them to a self contained bedsit and their progress plans showed this person was doing well and was maintaining the conditions of their tenancy agreement.

Major works and refurbishments were being done on the premises during the inspection. The registered manager had informed us beforehand to keep us updated on this. There were builders on site working to modernise all the communal areas of the premises. Notices were displayed in the reception area to inform people where the facilities had been relocated to on the premises, such as the games and computer room. Areas of the building were being developed to accommodate needs of people and the community. For example, two surgery spaces were being built for health practitioners to be based on site so that people who used the service would have immediate access to health care services. The registered manager explained that they had discussions with health and social care professionals. They came to an agreement that the service would be shaped to develop the some onsite facilities to be accessible for members of the public. This showed that the service served as an important part of the community.

A canteen was located in the service and we saw people were given sufficient drink and food during their mealtimes. People gave us feedback about the food that was provided. One person said, "The food is good and there is a choice," and another person explained, "There is enough choice in the food we eat here. I'm a vegetarian and the staff do cater for certain diets." However one person disagreed and said that the food did not meet their health need. We spoke with the registered manager who told us they would address this with the person and the staff manager of the canteen.

The canteen was run by an external provider and was open during breakfast and dinner times. To ensure people had enough food and drink a daily lunch club was held. We observed that people looked relaxed and engaged with staff whilst enjoying their meal. In addition to this, people had access to snacks, sandwiches and drinks donated to the service by a well known coffee chain. Care records showed the foods that people enjoyed and any allergies so staff were aware of any foods people should avoid.

People had access to health and social care professionals who regularly visited the service. People were offered treatment, advice and support to meet their medical and social care needs. Records showed that people had been assessed for care and treatment by physio therapists, social workers, community mental health nurses, substance misuse workers and street outreach workers. We spoke with two GPs who held a surgery at the home once a week for people. They were complimentary about how staff proactively supported people with their physical health and emphasised the good team work at the service which meant that people received good quality care.

One GP explained that even though people had been informed of the days and times of their visit, some people who were on the list to be seen did not arrive for their appointments because of their lifestyle and non-engagement. Therefore staff were faced with the challenge of encouraging and supporting people to engage and attend health appointments to help them stay well. Despite the challenges, staff consistently found ways of engaging with people when escorting them to appointments and offered support for people who had physical health needs, for example, poor mobility. One staff member said, "I see the paramedics here all the time, if they don't come I call them again. I can't stop caring, because people need medical attention."

The provider was skilled on how to obtain people's consent for care and treatment. The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection no one was subject to a DoLS

authorisation.

The registered manager implemented and improved procedures to adopt new ways of working with people to show how they consented to their care. As part of staff development the team adopted their own model of the Mental Capacity Act (MCA) assessment that suited the complex needs of people who used the service. They developed a MCA procedure to apply best practice to assess people's capacity in line with their complex needs. The new capacity assessments were then tested against an MCA audit tool. The local authority safeguarding, DoLS and MCA lead had given their input and suggestions. A new best interests assessment tool was then developed and implemented for people whose capacity fluctuated as a result of their substance misuse and we saw examples of how this was applied. Where people were unable to consent to their care about a specific decision because of their fluctuating capacity due to their health, their capacity was assessed and best interests decisions were made. For example, records showed for one person, it was identified that at specific times they frequently could not remember their online banking password to obtain their finances. Their password was changed on several occasions but this did not resolve the issue. This was discussed with the person and a best interests decision made to apply for an appointee to manage their finances to ensure the person had access to funds when needed.

We observed that staff obtained people's consent before supporting people with any aspect of care. Where people lacked the capacity to make specific decisions information showed that best interests meetings were held in consultation with people and the key health practitioners involved in their care.

Staff had completed training run by the local authority on the MCA and the records that we checked confirmed this. We listened to the staff handover and it was apparent that staff were skilled and knowledgeable about applying the principles of the MCA Act, when required. We noted due to people's substance misuse, fluctuating capacity was mentioned on several occasions. Care plans showed this was used as a key point of reference to make certain that assumptions were not made about people's capacity. For example, where people had refused care because they lacked capacity at one point in time but were able to make the same decision at a later point in time. Four people had signed their care records to show they had agreed to their care. When people had been involved with their care plan but refused to sign, this was documented in appropriate ways. For example by recording the reasons why the person refused to sign their plans.

Good

Is the service caring?

Our findings

People spoke about the kind and compassionate nature of the staff who supported them. One person said, "I do feel that the staff are overall kind and caring here" and another person said, "I do feel that the staff are compassionate and that they do listen."

There was a large reception area that led out to a large open space in the grounds where people could smoke. We saw there was frequent interaction between people and staff who asked about their day. They had meaningful conversations with people about the day ahead and we observed several people socialising with each other. People were open and trusting of the staff team and when people asked for things and/or to check on the days events, staff readily helped them. When people did not want to speak or interact, staff gave them the space and time to speak with them when they chose.

We observed that staff were in full control of the day to day operation of the service. They worked exceptionally well together and were observant, skilled and knew people very well and spoke respectfully about the people they cared for. They had radios to communicate with each other and were based on different floors. Staff explained that despite the building works they always had fluid communication with each other. They worked within the lone working guidelines and kept each other informed about their whereabouts in the home. We saw them communicating over radio if a person needed to be supported in and out of the lift and if a person was taking their visitors to different parts of the building. People's requests for help were met and on several occasions this was acted on.

People were supported by staff who showed empathy and understanding. Staff explained they that they faced challenges due to continually having to monitor and manage risks but said this outweighed the benefits of seeing people progress whilst using the service. People had written in their plans how they wished to be supported, such as, 'appreciate me because I am kind and you can support me with positive reinforcement.' We found that positive behaviour contracts were drawn up with people to show how this was being done. Some staff had worked in the service for a number of years and knew people's needs well. They told us about the circumstances that had led to people using the service and how they supported them with their health and wellbeing to maintain their independence. Daily notes were held electronically and contained the day to day contact staff had with people. Staff were observed to be treating people with respect.

Staff were considerate of people's eating habits. They understood that at times people would not eat regularly and skip the meals provided due to their alcohol intake. To ensure their nutritional needs were met staff regularly checked to see if people were eating and that food was available for people to eat throughout the day.

People were encouraged to maintain supportive relationships with those most important to them. Some people were accommodated in studio flats and their friends and family could stay overnight. Records showed that people were supported to re-establish relationships with the relatives they had lost contact with. We saw notes that demonstrated a staff member had taken the time to accompany a person to visit

their family member's place of burial and the person's wish to locate another relatives resting place. This showed that staff were sensitive to each person's needs and understood the relationships that were significant to them.

People told us their privacy and dignity was respected and their opinions and suggestions were listened to. Staff knocked on people's doors and waited to be given permission to enter their rooms and they were discreet when having conversations about people's care and support needs.

Advocacy and counselling services were available for people so they could have their views heard and be supported with emotional support, when this was needed.

Outstanding ☆

Is the service responsive?

Our findings

Responsive action was taken when people needed essential care; they were made to feel valued, respected and appreciated and part of the community they lived in. People told us their individual needs were met and that the care they received was personalised to meet their needs. One person explained, "I do feel that my keyworker involves me in my care when I see [them]. I definitely feel that I am progressing forward in my recovery." A health and social care professional told us, "The service is performing fantastically looking at the risk prevention strategy across the service. The provider is a key enabler and a more joined up approach is needed across services."

Referrals to the service were provided through a single point of access by the placing authority. The provider then carried out a thorough and comprehensive risk assessment and people's needs and preferences were discussed during an initial assessment meeting. If the provider's assessment demonstrated that they could not meet people's needs they were given information about how they could appeal the decision. This meant that people were given the opportunity to be listened to and have their case reviewed.

Care plans were highly personalised to meet people's specific health and social care needs and produced in an easy read format to make certain people understood the information they received. The registered manager had developed a project called the 'support planning and risk assessment project.' This included instructions for staff to follow about how they should approach person centred planning and how to provide the best outcomes for people. Examples of risk assessments and tools were available to guide staff on how these should be used. Support plans were reviewed in line with people's changing needs and involved their relatives and key professionals.

Personal goals were written by people to show the things they wished to achieve. The provider had taken the time to fully explore all the options available in order for them to achieve their aspirations and chosen ambitions. A staff member said, "There is a policy to keywork people every six weeks but with our client group practically this does not work, so we do this during an activity, like going to the shops, playing pool and engaging in conversations with them at reception." Initiatives that supported people were in place to build their confidence and self-esteem and promote inclusion. The provider explained that due to the complex needs of people they had to work much harder to engage them in frequent meetings. People were supported to engage in meaningful occupations and encouraged to choose the things they were passionate about. For example, information showed that one person collected cans and had raised money for a well know children's hospital, and continued to do so. A poster of the person's achievement was displayed to promote how other people could contribute to the person's cause and highlight how they had achieved their own personal goal.

Exceptional standards of care were delivered that had a positive impact on people's lives. Some people had written in their plans that 'the most important thing was getting their health back' and we found this was achieved. People's diagnosis and presenting needs were clearly recorded in their care records and actions were put in place to help them with their physical and mental health. One person's medical condition had a negative impact on their wellbeing; motivation and a reluctance to attend health appointments. Their

reduced mobility and chronic pain had an impact on their ability to safely manage their health and engage with substance misuse services. This led to a number of life threatening health conditions. The person had made a commitment during their one to one care planning meeting with the provider to abstain from drugs misuse. To best support the person the staff liaised with their key contact at a drug treatment service that could manage and understand the person's complex health needs. With encouragement from staff they began to attend their health appointments and regular reviews with their substance misuse nurse and consultant psychiatrist. The person was unable to collect their methadone due to their limited mobility so staff made arrangements to collect their prescription. This led to the person sustaining compliance with a methadone script for over six months after being non-compliant with this for a number of years. Reasonable adjustments were made to encourage the person's independence. For example, the provider had made arrangements for a hospital bed to be provided in the person's room to ensure their health needs were effectively treated. A district nurse regularly visited the person to help them with their treatment which led to a significant improvement in their condition and substantial progress was made with their recovery. The provider then made contact with social services to identify suitable move on accommodation. An extra care scheme was identified as an ideal placement to meet the person's needs. A viewing of the accommodation was arranged; the person was delighted with their surroundings and successfully moved into their new home. They were especially happy with the location because this was close to where their family member lived. A number of compliments were received by the provider from health professionals about the care they provided for the person. This showed that staff provided support that help people regain their dignity, to improve their wellbeing and motivated them to make progress.

Prevention and coping strategies had been co-produced by people and staff to help reduce their dependency on substances and clear plans were drawn up with people to show how they wished to be supported with their complex needs. Their journey of recovery was documented in their plans and their progress discussed at weekly staff meetings. For example, we saw evidence to show that one person with a dual diagnosis of mental health needs and substance misuse had moved into the service. They had previously resided in accommodation that didn't safely manage the risks associated with the person's needs. When they moved into Edward Gibbons House an assessment identified that the person was not taking their medicines and would not engage with drug and alcohol services and medical appointments. The person displayed behaviour that highly challenged the service.

The person was assessed as having the capacity to make decisions about their treatment and medicines. The staff in consultation with health professionals established risk management approaches that were acceptable to the person. For example, the person had refused to seek medical advice for their diabetes so staff made sure the person always had sugar and tea available during the day and night. This helped them to recognise the onset of Hypoglycemia and request a sugary tea to maintain their blood sugar levels. Positive and trusting relationships were developed between the person and staff over time, which helped to encourage the person to work more closely with the staff team. In turn, this led them to consent to engage with the drug and alcohol team and they stabilised their substance misuse. Engagement with mental health services was encouraged and the person began to engage more positively with the community practice nurse. The provider held discussions with the canteen staff to ensure a soft food diet was provided when it was identified the person had difficulty with eating due to their oral healthcare. This resulted to an increase in the person's appetite and they gained a healthy weight. After the person had achieved their goals they were supported to move into a service that enabled them to receive support with their mental health needs and was very happy with the outcome of this. This meant that the provider used different approaches that influenced the way people wanted to receive care, treatment and support.

The staff team worked in collaboration with other services which was fundamental to ensure people's complex needs were met. For one person their records showed that their health needs were deteriorating

which led them to call the emergency services frequently. However, when the ambulance crew arrived they refused treatment and displayed behaviour that was challenging. The person had a history of not taking the advice of medical professionals and discharging themselves from hospital before they received treatment. The provider highlighted there was a lack of interagency working between paramedics, hospital staff and other health professionals and a lack of understanding about the person's fluctuating capacity. To ensure a more responsive outcome for the person, the provider called for a multi-agency case conference. This led to a plan of action being agreed with the London ambulance service and other attending health professionals to make certain that any future calls to the emergency services would be flagged at accident and emergency. This was to ensure the paramedics were aware of the concerns around the person refusing treatment and their capacity so that the person was given priority upon arrival. In turn, this helped to reduce the time the person spent waiting for assessment so that the person was more likely to accept treatment as opposed to refusing essential care. At the time of the inspection the person was being provided with healthcare when needed and the paramedics had continued to help the person with a nebuliser to manage their health condition. This showed that the provider went the extra mile to enhance people's life chances despite the challenges faced.

A health professional told us, "Everyone is very supportive of the service. It's a way of keeping people from being homeless and engaged rather than suffering. They receive the care here that they need. This service provides a much better way of life for people."

People were given full choice and control about how they wished to be supported so they could continue to lead fulfilling and independent lives. Case studies evidenced how staff were responsive when supporting a person who was living with dementia. The person required additional support with their health and mobility needs and wished to maintain their independence as much as possible. The provider held a joint meeting with the person; their family and friend and first response team to discuss how they could holistically support the person whilst respecting their wishes. Following on from the meeting positive risk strategies were used to enable the person to exercise their right on how they chose to live their life. A robust missing person's protocol was established to ensure a fast response and escalation process in the event they were unable to find their way back to the service. An emergency identification card was given to the person to wear and had been used by members of the public to help the person return safely. It was noted that the person enjoyed their food at the service but at times would forget to eat. The staff team would remind the person before each mealtime and offer to accompany them during meal times if they wished. The dining area was monitored by staff to check if they arrived for their meals. The person enjoyed visiting their family and friends so staff supported them to apply for a taxicard and a freedom pass to allow them to travel independently and maintain a supportive family network. Over a period of time the staff team made observations about the person's condition and had intervened on several occasions when the person's behaviour gave cause for concern. A hospital admission determined that the person's dementia had progressed. Due to this, they were no longer able to manage and maintain aspects of their independent living skills. This led to a multi professional meeting with the person to discuss their future housing options. The person transitioned into sheltered accommodation which offered them the comfort of people who were a similar age group. The person's relative was highly complimentary about the help their family member received and for finding a home that was suitable to meet their needs. This meant that staff had an excellent understanding of people's needs and delivered individual care that supported positive change.

Complex needs workers were available to provide companionship for people and arrange activities that were flexible to meet people's specific needs. People told us they were taken on organised days out and had spent the summer months going to the seaside and the local parks and had movie nights and played pool together with staff. One person proudly showed us their art work and told us about the reasons for their keen interest in this. People had access to learning and wellbeing programmes that were run for people

experiencing or at the risk of homelessness. This was facilitated by professionals and located off site. This included a men's group which offered a supportive space for reflection and discussion, a writing and magazine group, digital media and photography classes, educational classes, a jobs club, interactive addiction support, acupuncture and a music club. This helped to maximise their independence and build their confidence and maintain their safety in and outside of the home.

The provider's peer consultants had held evaluation sessions that were attended by a number of people across the provider's services to discuss their experiences of support and the environment they lived in. People had fed back that the spaces and areas in the home were viewed as being a barrier to promote positive engagement between people and staff. Suggestions had been made about the provider opening up communal spaces so that people could feel included. The provider had listened to these suggestions and as part of the refurbishment we saw that a new open planned reception area had been built to promote further positive engagement between people and staff. The registered manager explained that other communal areas were also being developed to give people a sense of feeling part of a wider social circle. This demonstrated that people's views were listened to and acted on to ensure that people contributed to the running of the service and to remove any barriers to ensure a more inclusive environment.

Communication with key partners in health and social care services was consistently encouraged and sustained to ensure the service continued to meet people's needs. Staff spoke about the people who disengaged from a programme of support so engaged in meetings with other key organisations in order to provide responsive care. The provider linked in with an outreach worker from the reset drug and alcohol action team, who visited the service when people requested this and additionally offered training to staff, for example on suicide prevention. The outreach worker had helped to develop risk assessments with the staff team and had given them the appropriate tools and advice to use for drinkers. Staff had received training from the blue light project. This is alcohol concern's national initiative to develop alternative approaches and care pathways and treatment for resistant drinkers. The initiative is supported by Public Health England and 23 local authorities across the country. People had been referred to the blue light panel to explore the approaches to reducing the risks and impact of their behaviour. The registered manager stated the main aim was to reach out and help people with their substance misuse and they showed us plans that had been developed to mitigate risks.

Staff understood that people's cultural and spiritual needs were central to their support and wellbeing. Information showed that people had been supported with their diverse needs. People had written, 'I have been supported during Ramadan', 'I have been supported around my religious and cultural needs by all staff at EGH' and 'I have not been discriminated against about my religion.' The deputy manager had completed training in equality impact assessments and this was applied when the provider reviewed their policies and procedures. This was to ensure the provider did not discriminate against any disadvantaged groups.

The registered manager and health professionals had spoken sensitively with people about their end of life care, when necessary. People's choices and decisions about their end of life wishes were listened to and respected by staff who cared for them.

People told us they knew how to raise a complaint if they were dissatisfied with the service and who they would speak with if they had a concern. One person said, "I go to my keyworker if I need to make a complaint." The complaints policy included the external organisations people could escalate their complaints to if it was not satisfactorily resolved. The provider's satisfaction survey showed that people were happy with the complaints process and how complaints had been handled and resolved. Complaints been analysed and action had been taken to resolve these. For example, a complaint had been made that a person was unhappy about the food provided in the canteen. The provider carried out a comprehensive

food satisfaction survey for all the people who used the service. They collated the information and met with canteen manager to discuss the results which ensured that new food items were included on the menu to offer meal choices that people had requested.

Outstanding ☆

Is the service well-led?

Our findings

The service was exceptionally well-led. The culture of the service was open, transparent and dynamic. People and staff spoke in high regard about the registered manager and the deputy manager's capabilities to manage the service. Their comments included, "It's a very difficult service to manage, but the registered manager is great at implementing change and the deputy manager is always addressing issues with the residents" and "[The registered manager] is incredibly supportive an excellent bloke, great with staff, and he always makes time to talk to people." Health and social care professionals commented, "I think that the registered manager is "amazing" and there is a number of staff who are highly dedicated and committed to people. I have no criticism of the staff team" and "I can say that all the staff have an excellent ability to navigate the system which is well above and beyond of what is expected of the service."

On the second day of our visit we were shown a video that was filmed in the style of a documentary. People and staff were seen speaking about their values, care and their own personal challenges and goals. The registered manager explained this was presented during an internal senior manager team meeting to demonstrate that the service was meeting their aims and objectives and promoting a positive culture.

Comprehensive surveys had been undertaken by the provider to obtain people's views of the service. These comprised of questions about access to employment and work, the safety of the area they lived in and the quality of care people received. The results showed there had been an increase in people's levels of satisfaction in the way the service was run. The majority of the comments were positive and people had written their reasons for this, such as, 'My key worker always asked me what I wanted', 'I like to attend resident meetings so I am aware of what is going on around the hostel', 'I have not met any of my goals yet but will continue doing my best', 'Looking forward to getting HGV licence' 'This is my home, I'm happy here' and 'I was involved with my care all the way.' Some people had written that they did not want to be involved in training, their views were sometimes taken into account and one person had written they would like to be more involved. The provider listened to their feedback and used this to drive further improvements as detailed below.

People's feedback was used to drive the provider's quality assurance process. A wide variety of systems were in place to ensure an inclusive approach was taken to help people shape the service. The provider had set up a buddy workshop for people and offered an incentive for joining. This was so people could be supported by people who had similar experiences to them and they also supported the provider to develop the workshop.

Records showed that people had attended a feedback session with the provider and the commissioners from the local authority to assess the quality of the service. The aim was to involve them in an open discussion about their time at the service, if their specific cultural needs were met and what worked well and what could be done differently.

Information showed a benchmarking survey was used to establish the provider's performance based on Part 1 of the Care Act 2014 to demonstrate how they promoted individuals wellbeing. This feedback from people

showed two areas where the service could improve. This was for people to understand the role of everyone who was involved in their care and to look at ways to support people to better understand how the local authority made decisions about their care and support. In response to this the provider had created a series of pictorial posters to explain staff roles and how they supported people and a written introduction to explain the role of the local authority. These were placed in people's information packs when they first moved into the home. This showed the provider promoted inclusive and creative ways to involve people in developing and implementing change to achieve good outcomes for people.

Steps were taken by the provider to strive for excellence through consultation and rigorous challenge with other stakeholders to improve systems and provide exceptional outcomes for people. Records showed the registered manager facilitated joint partner meetings with a multi-disciplinary team and used a case conferencing approach to involve up to 12 partner agencies, including the police, anti-social behaviour team and street outreach team. Over a period of two years the registered manager passionately advocated that a person with high risk needs should be assessed by partner agencies so that they could be safely accommodated and receive the treatment for a health need that the provider had identified. However, this was difficult to achieve because the person refused intervention and support. Without an assessment the person could not be provided with the specialist support and accommodation they required. After a number of significant incidents that occurred in the service as a result of the person's behaviour the provider had no option but to evict the person.

During this time a partner agency was unable to identify any suitable accommodation for the person to meet their high risk needs and as a result the person became street homeless. Despite the eviction, the staff team at Edward Gibbons House continued to advocate for the person which led them to challenge a partner agency due to the risk to the person's safety. The registered manager explained this was extremely difficult as they were concerned about the need to sustain a positive working relationship with the partner agency. After another serious incident which led to legal proceedings an assessment of the person's needs was undertaken. The assessment highlighted the person had a health need that the provider had initially identified and discussed during the case conferences. This resulted in the person being accommodated in a service that was able to safely manage their needs.

Following the outcome of the case, the provider worked with partner agencies to develop and implement systems for reflective practice. This included a more collaborative and responsive approach in relation to challenging cases and the provider had been asked to present the case to the scrutiny panel who reviewed the person's access to health services. There had also been acceptance that there was a lack of service provision available for people who presented as high risk, which included many of the people accommodated at Edward Gibbons House. Therefore the provider demonstrated that they worked in partnership with other organisations and reflected on events to drive improvement in the quality of care and support provided to people using the service. A representative of the local authority commented that the provider had undertook a significant level of work with partners to safeguard and secure positive move on accommodation for a number of people and in some cases those in the most difficult circumstances. The registered manager commented, "I personally am very grateful to the Edward Gibbons House team for having the compassion to endure the challenges and see this case through to a positive outcome."

There was a strong organisational commitment and effective action to drive equality and inclusion across the workforce and deliver high quality care and support. Records showed that staff had raised concerns about the challenges they faced working with a person whose behaviour challenged the service. Staff felt disempowered as the only options were to call the police or evict the person. They acknowledged this went against the staff's core values and the provider's ethos of preventing homelessness. They spoke to the registered manager about their concerns who listened and swiftly arranged project meetings to try and find

a solution. They used quality improvement methods that had been introduced to support the delivery of healthcare and facilitated project meetings based on these tools. An emphasis was placed on brainstorming sessions with the staff team to discuss and reflect on all of the actions they took as a team to manage incidents of aggression and violence and reflect on what they might like to do differently in the future.

In light of this, a review of the rewards and sanctions policy took place and this was updated. Staff held discussions with people to make certain they understood this. Person centred tools were used to reinforce key messages to people about positive behaviour. It was also decided that the staff team would be made aware of the acceptable behaviour contracts at the point they were issued to people by the provider. This showed there was a collaborative approach taken to create a safe place for staff and people to manage behaviour that challenged and ensure that people were fully supported to maintain their accommodation at the service.

In addition to this, staff told us and records confirmed that they were supported by a psychologist who provided clinical supervision to the staff team. Once a week the psychologist facilitated a group where staff presented their cases and discussed issues related to areas such as homelessness and substance misuse to see how these could be effectively managed. A staff member explained that this gave them space to reflect and said the meetings were "extremely" helpful. They comment, "The team are all brilliant. We deal with the most complex cases and don't always consider the difficult work we do and the abuse we get. The after support you get is very important and we always get a debrief about any incidents during handover." This demonstrated there was a strong and collaborative approach to supporting staff and the work they did to ensure the best outcomes were achieved for people using the service.

The staff team were motivated and inspired to ensure people who used the service were provided with the best possible experiences. They spoke proudly about the service and the achievements they had accomplished as a team. This was despite the challenges they faced due to the complexities of the needs of the people they supported. We observed them carrying out their roles with confidence and ease when people wanted advice and support. The staff team were given ownership of auditing the care records of the people they key worked and peer reviewed the care records of their colleagues. This was viewed as beneficial to promote a consistent team approach to providing personalised care to people with complex needs and further aid their recovery.

Robust audits were in place to monitor the standards of care provided and the legal requirements of the Care Quality Commission. A variety of systems were in place to monitor people's care records, medicines, the environment, infection control and fire safety. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen at the service. The CQC had been informed of these events including significant incidents and safeguarding concerns, and during the inspection we found their plans of action had been implemented.