Care Quality Commission

Sanctuary Home Care Ltd

Sanctuary Home Care Ltd (London South)

Inspection report

c/o Trellis House, 1 Mill Road
Colliers Wood SW19 2NE
Tel: 020 8542 4641
Website: www.sanctuary-care.co.uk

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was announced. We told the provider two days before our visit that we would be coming. At our last inspection, 14 November 2013, we judged the service to be compliant with all the standards that we inspected.

This inspection was announced. We told the provider two days before our visit that we would be coming. At our last inspection on 13 June 2013, we judged the service to be compliant with all the standards that we inspected.

Sanctuary Home Care (London South) provides personal care and support to people living in four supported living

Summary of findings

schemes across south London. People living in the schemes have their own flats and access to communal facilities. The service provides support to adults of all ages, including those with learning disabilities, brain injuries, long-term health conditions and dementia. At the time of our visit there were approximately 165 people using the service. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People told us they felt safe using the service. They were provided with information about how to keep safe, including recognising and reporting abuse, bullying and discrimination. Staff were trained in safeguarding adults and the service had policies and procedures in place to ensure that the service responded appropriately to allegations or suspicions of abuse. The service ensured that people's human rights were respected when they did not have the capacity to consent to their care.

Each person who used the service had individual risk assessments and risk management plans so that staff had the necessary information to keep people safe from harm. The assessments were regularly reviewed to make sure the information was up to date.

Robust recruitment and fitness to work procedures were in place to protect people from the risks of being cared for by unsuitable staff. There were systems to ensure that enough staff were employed to meet people's needs, although many of the staff were not permanently employed.

The service had arrangements to make sure people had the medicine they needed to keep them safe whilst maintaining their independence. The provider carried out regular medication audits in all the services and took steps to ensure staff were competent to administer medicines. However, we identified one person's medicine was not being recorded accurately and this meant there was a risk that they were not taking it as prescribed.

People were satisfied with their care and said it enabled them to live their lives as they pleased. Staff had access to information, support and training that they needed to do their jobs well. The service provided a training programme that was designed to meet the needs of people currently using the service so that staff had the specialist knowledge they required to care for people effectively.

People's nutritional needs were assessed and care was planned so that staff knew what support people needed to protect them from the risks of malnutrition and dehydration. This included meeting people's preferences and cultural needs. Care plans contained information about the healthcare support people needed and records showed they were supported to access healthcare professionals when required.

People told us they had a good relationship with staff and staff were able to demonstrate they knew people well. Staff knew about the importance of treating people with compassion and empathy, respecting their rights to privacy and dignity and promoting equality and diversity. They were able to tell us how they did this and people confirmed this was the case.

People were given information about the service in a format that met their needs. This meant that they were kept informed about their care and had the information they needed to be involved in making informed decisions.

People were involved in planning their care in such a way as to put the person's needs, preferences and what was important to them at its centre. People were encouraged to take the lead in deciding how to spend their time and to be involved in their local community. The service took steps to ensure that care plans were kept up to date and involved people in reviewing them so that any changes people wanted or needed were made.

The service had several methods through which people could express their views and concerns so that different ways of communicating were catered for. This included meetings, surveys and being asked verbally as part of care reviews and quality checks. The service responded promptly to concerns and complaints and made sure people were satisfied with the outcomes.

People were involved in the running of the service. This included involving people in staff recruitment, complaints management, policy development and changes to the service. This meant there was a culture of

Summary of findings

inclusion and people's input was valued. People were encouraged to work together to decide how the service should be run. Staff felt able to raise any concerns they had and had the opportunity to express their opinions.

The provider had a number of audits and quality assurance programmes in place. These included action plans so the provider could monitor whether necessary changes were made and ensure high standards were being maintained. The service had mechanisms in place to learn from incidents and adverse events.

The service had links with other organisations and expert advice to enable them to deliver care in line with current best practice guidance. Managers monitored the quality of care that staff were providing through observation and supervision. Staff were given the opportunity to discuss good practice in meetings.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. We found that improvement was required in relation to medicines records.

People and staff had the information they needed to recognise and report signs of avoidable harm, discrimination and abuse. Staff understood their responsibilities in terms of the Mental Capacity Act 2005. Risks to individual people were identified and managed through risk assessment and management plans.

There were robust recruitment procedures to ensure only suitable staff were employed and there were sufficient numbers of staff to keep people safe.

Is the service effective?

Good

The service was effective. There was sufficient training, supervision and support for staff to ensure they were equipped with the necessary knowledge and skills.

People were supported to have enough suitable food and drink to meet their needs, including culturally appropriate foods. Extra monitoring and support was in place for people who were at risk of malnutrition and dehydration. People were supported to access healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring. Staff took the time to build meaningful relationships with people. People felt valued and respected and the service was committed to the principles of dignity, equality and diversity.

People were supported to have sufficient information to make informed decisions about their care and these were acted on. The service used innovative methods of relaying information to people who did not communicate verbally or who could not speak English. The service involved people in decision-making at each stage of their care assessment, delivery and reviews.

Is the service responsive?

Good

The service was responsive. Care was planned and delivered in such a way as to put the person's needs, preferences and what was important to them at its centre. People were encouraged to take the lead in deciding how to spend their time and to be involved in their local community.

The service encouraged people to express their views and these were acted on. There were several ways in which people could do this so that everybody could have their say. The service made sure people were satisfied with the handling of their complaints and concerns.

Summary of findings

Is the service well-led?

Good

The service was well-led. People were actively involved in the running of the service through committees and focus groups, involvement in staff recruitment and policy development and audits that included asking people for their opinions about the service.

Staff and people who used the service had opportunities to raise concerns and felt confident doing so. The service had systems in place to ensure they learned from incidents, accidents and complaints. These were monitored so that any trends or increased risks could be addressed.

The service had links with other organisations and expert advice to enable them to deliver care in line with current best practice guidance. Managers monitored the quality of care that staff were providing through observation and supervision.

Sanctuary Home Care Ltd (London South)

Detailed findings

Background to this inspection

This inspection was carried out by an inspector, a pharmacist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed previous inspection reports to gather information about the service. We reviewed information that we had received from stakeholders and other professionals working alongside the service, including reports from commissioning bodies, and we looked at notifications that providers are required to send to us about certain events that take place in services. We looked at the provider information return (PIR) which we asked the home to submit. This is a form that asks the provider to give some key information about its service, how it is meeting the five questions, and what improvements they plan to make.

We spoke with 20 people who used the service and one relative of a person who used the service, either in person or by telephone. We spoke with the registered manager and interviewed two scheme managers, three team leaders, an activities coordinator and six support workers either in person, by telephone or via an email questionnaire.

During the visit, we reviewed records including eleven people's care plans and records of care, five staff files and other records relating to the management of the service (such as staff rotas, meeting minutes and reports from audits).

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

As part of this inspection, medicines management was inspected by a pharmacist to determine whether there were safe and effective arrangements in place and people were receiving their medicines as prescribed.

At one of the housing schemes we saw that a medicine to prevent blood clots (an anticoagulant) was not documented on the current medicine administration record (MAR) for one person, and there was no evidence that it had been given for two days. The medicines hospital record book was kept in the service's office and there was no evidence of the current dose prescribed in this person's flat. There was also one omission in recording administration on the previous month's MAR. This means that we could not be sure that this medicine was being given as prescribed. We did not find any omissions in other records.

We saw in one of the four housing schemes, where staff were administering or supporting people with their medication, that there was evidence of people's current medicines on the MAR. We looked at risk assessments and care plans and saw that there was detailed information on the level of support that people required. One person had been assessed as being at risk due to forgetting to take their medicines and there was an action plan for staff to check the person's medicine stock and MARs at each visit. This meant staff could make sure the person had the medicine they needed to keep them safe whilst maintaining their independence.

Some people were able to take their own medicines and they told us how they took them and how they went to their doctor to discuss any health problems. There was a record in their file detailing what medicines they were taking and also a consent form which they signed stating that they took responsibility for their medicines.

We looked at the recording of medicines on the MAR of eight people in two housing schemes. Overall, they were completed accurately. We saw that in one service there had been shortages of supplies of medicines for some people. There was evidence that the service had met with the pharmacist supplier and the GP prescriber and these concerns had since been resolved.

The provider had policies and procedures in place to manage medicines safely and report medicines errors. This also included the safe management of anticoagulants. The provider carried out regular medication audits in all the services and there was evidence of training in safe medicines management and regular assessments of the competency of care workers.

People told us they felt safe using the service. One person said, "Oh yes: they ring every morning and say 'Everything alright – had a good night?'" The service assessed each person's vulnerability to harassment and discrimination and put measures in place to reduce risks, such as giving people information on how to recognise and report abuse, bullying and discrimination. We saw evidence that recognising and reporting abuse was discussed at a tenants' meeting. People who had responded to a survey carried out by the provider said they felt safe and secure and knew how to recognise and report abuse.

Staff were trained in recognising and reporting abuse. There was an up-to-date safeguarding procedure, which covered how to recognise, record, respond to and report abuse and supporting alleged victims. Staff we spoke with were able to accurately summarise the procedure, including use of a whistleblowing procedure if their concerns were not addressed. We saw records of where suspected or alleged abuse had been recorded on a log sheet and the service had made prompt referrals to the local authority safeguarding team. Where allegations had been made about staff, the provider had investigated and carried out disciplinary processes where necessary. This showed that the provider had appropriate arrangements in place to report and respond to suspected abuse. The log also enabled the provider to monitor allegations and suspicions for any patterns that suggested a person was being abused or the service was unsafe.

People had assessments of their mental capacity when they required support to make decisions, so that care was carried out in accordance with their wishes when they were able to give consent. The necessary legal procedures were followed when people did not have capacity. We found an example in one person's file where they had been assessed as not having capacity to make a decision. The service had held a meeting with the person and their relatives, health professionals and others involved in the person's care. This was to make a joint decision about what course of action was in the person's best interests, in line with the requirements of the Mental Capacity Act 2005 (MCA) and the service's own policies. Staff had knowledge

Requires Improvement

Is the service safe?

assessments about the MCA and safeguarding people from abuse. Where they answered incorrectly, supervisors had discussed the correct responses with them. Staff we spoke with were familiar with the relevant procedures to ensure that the service acted within the law and respected people's rights.

Staff received training in responding to behaviour that challenges services. All staff we spoke with were able to tell us how they would respond in these situations in such a way as to protect people and themselves from harm and respect people's rights.

We looked at eleven care files and saw that each person had individual risk assessments and risk management plans. Each risk assessment included numerical risk ratings, the interventions required and a revised rating to show how the risks were reduced by interventions. The assessments had been reviewed annually, or more frequently if required such as when an incident took place or if a safeguarding concern was raised. Risk areas such as moving and handling, environmental risks in people's homes and people administering their own medicines were included, depending on need. Where risks were identified, people had risk management plans in place. These included information about how to spot any hazards and what action to take so that staff knew how to prevent incidents and keep people safe. Staff told us that any new risks that arose would be discussed confidentially in staff meetings and passed on verbally to staff on each shift until the person's risk assessments had been reviewed.

Each person had their own personal emergency evacuation plan. This was so that staff knew what support each person needed to leave the building safely in case of emergency. Each housing scheme had a business continuity plan detailing what action needed to be taken in response to various emergencies so that people remained in a place of safety.

Staff files showed that the service had carried out checks on new staff to ensure they were suitable for the role. The checks included criminal record checks, references, evidence of qualifications, job history, proof of identity and proof of right to work in the United Kingdom. We saw evidence that, where investigations had shown that staff were unfit to work in social care or had been found to have exposed people to abuse, they were referred to the appropriate professional body to prevent them from being re-employed. Staff we spoke with felt there were enough staff employed to keep people safe. Rotas showed that set staffing levels were met and there was flexibility so that shifts could be changed to meet people's needs.

Good

Is the service effective?

Our findings

People told us the care they received was effective. One person said, "[Staff] do everything I need. I have the best quality of life and I recommend Sanctuary. Put your name down for when you retire!" Another person said, "My quality of life is just fine and to my satisfaction. Yes, I would recommend this to others in my situation." One person told us the competence of staff was variable, but other people said they were satisfied with all the staff. People's care plans stated the overall aims of their care package so that staff knew what the focus of the care they delivered should be. This included people's individual goals and needs.

Managers told us the service was supporting people with an increasingly wide and complex range of needs. To support staff to have the knowledge and skills to carry out their roles effectively, the service had employed a qualified trainer. This meant that staff would have consistent training across the four housing schemes and there was access to expert advice about how to care for people. The service was a member of a national accreditation scheme to support their delivery of good practice.

The service had a dementia strategy, showing how the service was being developed to use current research and guidance in supporting people living with dementia. Several senior staff members told us they had also had training from a university that the service had links with. The registered manager told us they had a plan in place to have at least two dementia specialists working in each housing scheme. We saw evidence that staff had received training in areas such as stroke awareness, supported living, challenging behaviour and dementia awareness. There was a training matrix that was used to monitor mandatory training and make sure each staff member was up to date.

New staff had an induction. Records showed that the induction included formal training sessions and shadowing more experienced staff. Staff confirmed this and told us they had regular supervision and annual appraisals, which included discussion of any concerns around their performance. Staff also told us that any gaps in their training were addressed, so they had the necessary knowledge and skills to carry out their responsibilities.

People's nutritional needs were assessed and care plans showed what support people needed to ensure they had sufficient amounts of suitable food and drink. This included meeting dietary requirements for people with health conditions such as diabetes. People's preferences were recorded and care plans prompted staff to respect people's choices about food. Care records showed that people were given food that was appropriate to their cultural backgrounds as recorded in care plans. One person told us, "A lady comes and cooks my [culturally appropriate] food. My lady who is [from my native country] is on holiday this week and they have found someone else."

Risk assessments showed that where people had been assessed as being at risk of malnutrition, extra measures had been put in place to support them. These included support with shopping and meal preparation to ensure that people were eating food that was appropriate for them. Staff told us they routinely asked people what they had had to eat and drink that day and checked care notes and food supplies in the person's home.

People whose files we reviewed had signed consent forms to show they agreed to the service sharing their personal information with other professionals when required. This helped to ensure that healthcare services had the information they needed to support people.

Assessments covered any other services people required, such as physiotherapists or dieticians. Health professionals involved in the person's care were recorded in care plans. There were records of contact with healthcare professionals showing that people were supported to access them when required. Staff we spoke with were aware of these and knew how to contact people's doctors or social workers if their healthcare needs were not being met.

Good

Is the service caring?

Our findings

People told us they had a good relationship with staff. One person said the agency was currently in the process of accommodating their request for a specific member of staff to take the lead on their care. Another person said staff "do do a lot for me and listen to what I say." A third person told us, "Staff are kind and helpful." People told us staff were reliable and came at the times when they were expected to.

Staff spoke about the importance of compassion and empathy, particularly when people received bad news or were feeling unhappy. All of the people we spoke with said that staff were approachable, they could chat with the staff and that they were listened to. We observed several interactions between staff and people who used the service that showed staff were familiar with people's backgrounds, preferences and interests. For example, we saw a staff member at one of the housing schemes chatting with a person who used the service about a wedding in the person's family.

Staff we spoke with were aware of the principles of equality and diversity and gave examples of how they reflected these values in their work. One member of the management team told us they had ensured their scheme's tenants' committee had a diverse membership in terms of background and ability, so that decisions made by the committee were representative of the whole group of people who used the service.

There was evidence that people were involved in planning their care. People's needs were assessed before they began using the service and regularly reviewed with them. Assessments recorded the person's own view of what their needs were as well as that of the assessing professional. People had signed their care plans and assessments to show that they had been involved. The assessments and reviews recorded people's preferences for how they would like their care delivered. For example, one person had stated that they would prefer to have staff of the same gender and ethnic origin delivering their personal care, and this had been added to their care plan. Another person had said they would like to stay up later when their favourite sport was on the television and staff accommodated this by supporting them to go to bed later on those days. Some people's care plans stated that they did not always want support with some aspects of their care and that staff should enable people to make decisions about what support they wanted at each visit. We saw examples in care notes, and staff gave further examples, of times when people had expressed preferences for things to be done differently from their usual routine and staff had accommodated their wishes.

People whose care files we reviewed had signed a form to say they had received information about the service, including a user guide. This meant people had the information they needed to make decisions about their care and whom to speak to if they needed more information. The user guide contained information about the care planning and review process and how people were involved, the service's keyworking scheme, how to access support and professional boundaries that staff should observe. The information was available in an easy-read format so that people who had difficulty reading could access it. We saw examples of the information printed in different languages so people who did not read English could also access it.

There was evidence that staff discussed meeting the needs of people who did not speak English. They told us about using non-verbal communication and were engaging with one person's family who had agreed to teach staff some phrases in their native language. The person had been supported to access religious services in their language. Staff had worked with another person who did not speak English and their family to develop a pictorial communication board. The service was able to access interpreters to deliver more complex information to people.

We saw an example of a newsletter sent to people who used the service. This was used to give people information about upcoming events and activities, notifications of new arrivals to the service and people who had died, and groups that people could join such as a choir. This meant that people received sufficient information to allow them to choose how to spend their time. Some people had contributed information about themselves, their life histories and interests so that people who used the service could learn about one another and to encourage people to form friendships.

Staff we spoke with were aware of the importance of respecting people's privacy and dignity. They gave examples of how they did this, such as by keeping doors closed when supporting people with personal care and not sharing people's personal information unless necessary. We saw the service's privacy and dignity policy, which

Good

Is the service caring?

covered areas such as employing a sensitive manner when gathering intimate information about people during assessments. People who used the service received an information leaflet about how their personal data was kept confidential.

People's care plans contained information about how they would like staff to support their privacy and dignity. One person's care plan stated that because they had found a particular health problem difficult to deal with, staff should follow the care plan to preserve their dignity and encourage socialising to promote self-esteem. Another person's care plan said that although they required support at times, they wished for staff to value their independence. This person's care records showed that staff allowed the person to do things for themselves whenever possible and respected their wishes when they declined help. One person told us they had become more independent since using the service and said, "I am content and would recommend Sanctuary." Another person said, "They let me do things for myself. [Staff member] helps me when I need it."

We saw results from a survey of people who used the service carried out in 2014. People said they were satisfied that staff respected their privacy and dignity. Between 90% and 100% of people in each housing scheme who completed the survey said they were fully involved in planning their care and support, that their opinions were taken into account and that they were listened to.

Good

Is the service responsive?

Our findings

Care plans were person-centred and focussed on what people would like staff to do so that their needs and preferences were met. This included how the person should be supported to access the community and activities provided by the service, should they wish to do so, and to ensure they were protected from the risks of social isolation. Staff we spoke with understood the principles of person centred care and said they planned and delivered care in such a way as to ensure the person's wishes and preferences were central to every decision.

Care plans gave details of what contact people had with their friends and families and whether they needed support from staff to maintain the contact. People told us these needs were met and they were encouraged to interact with their families when they were able. Reviews of care plans showed that people were happy with the support they received to maintain social contact and practise their religions, where relevant.

People's assessments showed what their emotional, health, nutritional and support needs were and gave details of how they should be met. Each person had stated what was important to them, what their strengths were and what they needed more help with. We saw that when care plans were reviewed, changes were made where required to reflect people's changing needs. This helped to ensure that people received personalised care that was responsive to their needs. However, we found that one person whose assessment recorded that they had lost weight before they started to use the service did not have a nutritional risk assessment or any records of ongoing weight monitoring. The person's daily notes showed that staff gave them a nutritional supplement, but there was no information about this in the care plan. This meant that the person may have been at risk of malnutrition due to a lack of monitoring or incorrect use of supplements caused by a lack of updates to the care plan.

Care records showed that staff asked people for their consent before providing care. Staff recorded if people declined care and noted that they did not deliver care when this happened. They told us they always ensured people had all the necessary information about what they were consenting to. Records showed that appropriate people were consulted if the person did not have capacity to consent, to make sure their human and legal rights were respected.

People had access to a tenants' committee. The committee met so people could make decisions about activities that took place and people had a fund that they contributed to for extra activities. This meant that people were enabled to socialise and take part in activities that were important to them and suited their budgets. The registered manager told us that people had recently met the local mayor and had had a band come in to play music for them. We saw from a newsletter that people at one of the housing schemes had been supported to hold a tabletop sale to raise money for their tenants' fund. This showed that the service promoted and encouraged community involvement.

Records showed that people were asked their opinions about their care as part of the assessment and review processes. Some people had fed back that they would like changes in the way staff supported them and these were incorporated into their care plans. We saw examples of reviews where people had requested support in areas that were not covered by their current care package. The service had responded by promptly requesting the necessary resources from commissioning bodies.

Where people and their relatives had raised concerns, these were recorded in people's files so any actions could be monitored through care records. Records showed that the service responded quickly to people's concerns and agreed actions with them. These were then discussed in staff supervision and team meetings along with actions for staff to observe, such as making sure they spoke in plain English so people understood them. Staff gave examples of times when they had changed the way they cared for people in response to their comments or concerns. One person told us, "I didn't like being woken up at [time] so I asked them to change my morning call and they did."

There was a complaints policy and people received information in a suitable format about this when they began using the service. The information included whom people could contact if the complaint was not resolved to their satisfaction. We saw some records of complaints, which showed that the service had responded quickly in line with the complaints procedure. Actions had been

Good

Is the service responsive?

identified from the complaints and allocated to staff. A recent survey of people who used the service showed that people knew how to complain and were satisfied with the handling of any complaints they had made.

Good

Is the service well-led?

Our findings

People were actively involved in the running of the service. Information packs people were given when they began using the service contained information about how they could be involved. The information covered involvement in staff recruitment, policy development, complaints management, changes to the service and participation in surveys and meetings including discussion and focus groups. This meant there was a culture of inclusion and people's input was valued. The service had a tenants' committee, which met regularly to discuss the service. Each housing scheme had held a tenants' meeting within three months of our visit. People we spoke with were aware of the meetings. One person said they were not encouraged to take part. However, one of the scheme managers told us they had recently begun approaching each person individually to talk about any concerns they might have after one person told them not everybody wished or was able to attend meetings.

People had the opportunity to comment on the service and request activities. Minutes from the meetings showed that people had been offered the opportunity to learn computer literacy skills, attend live music sessions and join planned activities and trips. People were invited to give feedback and were reminded about how to make compliments and complaints to the service. We saw one example of the service agreeing to change an activity in response to people's feedback at the meeting.

People told us managers and senior staff were approachable and so they felt confident to raise any concerns they had in meetings and with managers. One person told us, "[Scheme manager] is good at running things." We saw a copy of a newsletter, which the registered manager told us they had developed at the request of people who used the service. This helped to keep people informed of events at the service if they were not able to attend meetings.

The service had a 'customer engagement and insight strategy.' The strategy covered empowerment, equality and diversity, accountability, continuous improvement and inclusion and accessibility. There was a plan for developing each of these areas over the next two years, including actions such as involving people who use the service in carrying out quality checks and taking the lead in feedback sessions.

We saw the results of the service's quality assurance audits, which were carried out at least six monthly. The audits included checks on people's involvement in the service, activities and a survey for people who used the service. The survey covered people's views on safety and security, care and support, communication and information and privacy and dignity. Their responses were fed into the audit and any actions required were noted. In the most recent survey, people had indicated that they were happy with the service and said they were kept informed of any changes to their care and how to complain. The audits also monitored staffing and recruitment, training, supervision and appraisal, safeguarding and safety, medicine checks, complaints, care plans and reviews. Audits also covered progress on action plans. Where shortfalls were found, the provider put action plans in place with timescales for them to be completed by and checked in the following audit that they were complete. This showed that the provider had an effective system to monitor the quality of the service.

We saw records of staff meetings, where teams had discussed issues such as teamworking. Staff told us they felt listened to. All but one of the staff we spoke with said they felt comfortable raising any concerns they might have at team meetings and supervision. The member of staff who did not feel comfortable told us they did not feel they had enough feedback from managers. Other staff said they did not receive feedback from spot checks. However, we saw evidence that feedback was discussed in supervision if the staff member needed to do anything differently.

People received information about the service's vision and aims when they began using the service. Staff were able to describe these consistently and said the service focused on providing care that took into count people's individuality and different needs. One staff member told us, "They put [people who use the service] first. I wouldn't want to work for them if they didn't."

We spoke with the registered manager and two of the four scheme managers. All agreed that the service's biggest challenge was providing a high-quality service despite cuts in resources. They told us they looked for innovative ways of using resources. Staff gave examples of how they did this, such as involving people in raising their own money for extra activities should they wish to do so.

Safeguarding concerns and outcomes were discussed with frontline staff at team meetings so that they were aware of any issues and action to be taken. We saw evidence that

Good

Is the service well-led?

senior management sent messages to scheme managers to ensure all were aware of the provider's incident management protocol. In the months prior to our visit, the service had identified an increase in the number of medicine administration errors. We looked at audits and all reported drug errors for the last five months. There was evidence of a marked reduction in concerns and errors being reported in the last two months. The errors had been discussed at staff meetings during this period and staff had had administration practice sessions. This showed that the service was responding to and learning from incidents and concerns.

The service had an action plan to improve the quality of the service. The provider planned to put a new care planning system in place to ensure information was managed well across the organisation.

The service had links with a university programme researching best practice in dementia care. We saw evidence that the registered manager had undertaken a course on leadership in dementia care. They told us this had been valuable in making their service more person-centred and that they had used the university's research and guidance to help staff understand what life may be like for people living with dementia. We saw examples of memos that the provider sent to scheme managers to disseminate information that promoted good practice. Areas covered included staff training and actions to be taken following a complaint. Minutes from a managers' meeting two weeks before our visit showed that managers discussed good practice and covered topics such as staff recruitment, safeguarding and feedback from the dementia specialists that the service received training from. There was an organisation-wide magazine available to all staff and this featured best practice guidance and compliments received from people who used the service.

There were quality assurance systems in place. People received information about these when they began using the service. There was evidence that people had the opportunity to complete evaluation forms about their care. Managers carried out spot checks at different times of the day and night to make sure staff were carrying out their jobs as instructed. We saw planners that showed each staff member had received or was due to receive support and monitoring every month in the form of a spot check, supervision, appraisal or observation. The spot checks included asking people for their opinions about their care. Where spot checks identified areas for improvement, action plans were set and monitored through supervision and further spot checks. This system was able to continually monitor the quality of care provided and ensure that standards remained high.