Dimensions Somerset Sev Limited

Dimensions Somerset Yeovil Domiciliary Care Office

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18, 19 and 22 January 2018 and was announced. This is the first inspection for the provider.

Dimensions Somerset Yeovil Domiciliary Care Office is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to, older and younger disabled adults including people on the autistic spectrum.

This service provides care and support to 94 people living in 13 'supported living' settings, so that they can live in their own home as independently as possible. Many of the people using the service required up to 24-hour support from staff due to their disabilities. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The houses were located in a range of areas from the countryside to in a town. Each house had multiple occupation. Houses in multiple occupation are properties where at least three people in more than one household share toilet, bathroom or kitchen facilities. Some houses had individual areas created for people who struggled to share with others. There were offices in each home and some had sleep-in rooms for staff.

Not everyone using Dimensions Somerset Yeovil Domiciliary Care Office receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Each supported living home had a team manager who reported directly to the registered manager. There was a performance manager working alongside the registered manager and providing additional support to the team managers.

People and their relatives using the service thought they were kept safe. Most medicines were managed safely. Improvements could be made with some administration records and practices. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others.

The management had developed positive relationships with people. People and their relatives were happy with the support they received. There were some mixed feelings about whether there were enough staff to meet their needs from the relatives. Inconsistencies were found with how people's recruitment had been managed throughout the service.

People were protected from potential abuse because staff understood how to recognise signs of abuse and knew who to report it to. When there had been accidents or incidents systems were in place to demonstrate lessons learnt and how improvements were made. Staff had been trained in areas to have skills and knowledge required to effectively support people. People told us their healthcare needs were met and staff supported them to see other health professionals

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible. When people lacked capacity decisions had been made on their behalf following current legislation. People were supported, when required, to eat a healthy, balanced diet.

Care and support was personalised to each person which ensured they were able to make choices about their day to day lives. Care plans reflected people's needs and wishes and they had been involved where possible. People and their relatives knew how to complain and there was a system in place to manage them.

People and their relatives told us, and we observed, that staff were kind and patient. People's privacy and dignity was respected by staff. Their cultural or religious needs were valued. People, or their representatives, were involved in decisions about the care and support they received. The provider was developing systems to ensure people had a dignified death.

The service was well led and shortfalls identified during the inspection had mainly been identified by the management. There was a proactive approach from management and additional scrutiny was being sourced from external agencies. The provider had completed most statutory notifications in line with legislation to inform external agencies of significant events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People could expect to receive their medicines as they had been prescribed. Some minor improvements were required for medicines administration records and practices.

People were protected from the risks associated with poor staff recruitment because a recruitment procedure was followed for new staff.

People were protected from risks because care plans contained guidance for staff and risk assessments were in place.

People had risks of potential abuse or harm minimised because staff understood the correct processes to be followed.

Is the service effective?

Good

The service was effective

People were supported by staff who had the skills and knowledge to meet their needs.

People had decisions made in line with current national guidance.

People had access to medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Is the service caring?

Good

The service was caring.

People were able to make choices and staff respected their decisions.

People's privacy and dignity were respected most of the time by staff.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able to exercise their religious and cultural beliefs.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff. Care plans contained important information to provide guidance for staff.

People benefitted because staff made efforts to engage with people throughout the day. Activities were in place in accordance with people's interests.

People knew how to raise concerns and there was a system in place to manage complaints.

People were beginning to be supported to have a dignified death because the provider was developing systems.

Is the service well-led?

Good

The service was well led.

People were supported by a management who made changes to systems when they identified things could be improved.

People were using a service which had clear scrutiny to ensure they were receiving care and treatment in line with their needs.

People and their relatives were involved in decisions about how the service was being run.

People benefitted from using a service which had staff who felt supported and listened to.

Dimensions Somerset Yeovil Domiciliary Care Office

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 18, 19 and 22 January 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is across multiple locations and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 18 January 2018 and ended on 22 January 2018. It included spending time in the office, visiting three supported living houses, speaking with staff and telephone calls to relatives. We visited the office location on 18 and 22 January 2018 to see the manager and office staff; and to review care records and policies and procedures.

It was carried out by one adult social care inspector and an expert by experience who made telephone calls. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service for people.

The provider had not completed a Provider Information Return (PIR) because there had been an internal error. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection we looked at things which would have been on the PIR. We spoke with other health and social care professionals and looked at other information we held about the service before the inspection visit.

We spoke with nine people who lived in the three supported living homes. We also had informal conversations with people in the supported living houses as we walked around and completed the inspection. We spoke with the registered manager, operations director, performance manager and 10 members of staff including team managers, assistant team managers and support workers. During the inspection, on the telephone we spoke with 12 relatives.

We looked at six people's care records. We observed care and support in communal areas. We looked at three staff files, information received from the provider, staff rotas, quality assurance audits, staff training records, the complaints and complements system, medication files, environmental files, statement of purpose and a selection of the provider's policies.

Following the inspection we asked for further information including provider policies, other documents relating to the service and staff recruitment records. We received all of this information in the time scales given.

Good

Is the service safe?

Our findings

Most people's medicine was managed safely. Staff promoted independence and encouraged people to manage their medicine as much as possible. Some people were supported by staff and others managed their own medicine with staff overseeing it. Relatives had mixed opinions about the management of medicine. Some relatives said, "Medication is given regularly and on time" and, "[They] pay attention to medication and see that things get given at the right time". Whilst another relative was a little concerned their family member who self-administered their medicines did not always have checks completed by staff. During the inspection we saw people who managed their own medicine were being monitored by staff.

Medicines were stored securely in people's homes and staff kept records for medicines which were being administered. There were systems in place to ensure the safe management of medicines. The registered manager told us all medicine errors were now processed as a safeguarding. They liaised with the local authority to ensure they were being open and transparent.

Some people had medicines when required to help them with anxiety levels or pain. There were clear guidelines in place which instructed staff when they should be given, what the signs to look out for, the frequency and quantity. This was important because some people were unable to verbally communicate their needs. It ensured people were receiving their medicine consistently even by staff who knew them less well because they were newer.

The provider was promoting the reduction in the use of medicine to support people with learning disabilities and behaviours which could challenge. This was to improve people's well-being. For example, one person was particularly anxious on the day of the inspection. Staff had the option to use a medicine to help them. Instead the manager told us the staff were sitting and supporting the person to relax. Their MARs clearly showed staff used other strategies rather than medicine.

However, one person told a member of staff they had a headache. The member of staff realised the person had no medicine administration records (MARs) in place because they had been sent home when the person was staying with family overnight. By not having MARs at the home there was a risk medicine could be given incorrectly and national guidance was not always being followed. The team manager immediately addressed this. They wrote up a new record for the medicine and informed us in future only copies would be sent home with the person. Another person was administered medicines and the member of staff signed it had been taken when it had only been made available to them. By inaccurately completing MARs there was no clear record of medicines taken and therefore no way to monitor the effectiveness. This single error was highlighted to senior staff during the inspection and addressed. One member of staff confirmed they were due a visit from the pharmacist and will update their practice in line with advice from them.

People were kept safe when they had specific health conditions because there were clear guidelines in place for staff to follow. This included assessing risks and using specific equipment. One person had epilepsy. They had a clear care plan in place around this which identified the risks, described symptoms of a decline in health and guidance for staff. There was special technology in place to alert staff whilst they were in the bath

if their health declined. All staff were aware of this equipment and guidance on how to support the person. Other people with diabetes had guidance to inform staff what were high and low blood sugar readings and how to identify if their health declined. Staff confirmed they were familiar with how to support these people and one person was supported appropriately during the inspection when their readings had changed. However, one person with diabetes had recently been given a new machine to check their blood sugar. No staff had checked with the health professionals whether this machine needed calibrating to ensure accurate readings. During the inspection the team manager found out how to manage the machine and make sure it was safe to use in future.

People were kept safe because there was a recruitment procedure in place prior to new staff starting work. This included references from previous employers and checks to ensure staff were suitable to work with vulnerable people. When the provider struggled to receive references for new staff they created risk assessments and the staff did not work alone. Some people were involved in the recruitment process. One member of staff told us, "[Name of person] is involved when she wants to be" and explained they would come into the room during staff interviews. Another member of staff said, "Behaviours would show us when people are not comfortable" around new staff. By involving people and respecting their views during recruitment they were enabling them to help choose appropriate staff to work with them. The registered manager showed us the new electronic system in place which would highlight to team managers if there was an issue at recruitment.

People and their relatives told us they were safe. All people able to told us they felt safe. One person told us staff did not hurt them. Another person told us staff helped them have a bath and made sure the water was not too hot. One relative told us the care is "Safe and going very well". Other relatives said their family members were, "Safe and well looked after" and the, "Staff are fantastic" and feel that the care given is, "Safe". Staff told us, "It is safe here" and, "We make sure they [meaning the people] are kept safe".

People were kept safe from potential abuse because staff knew how to recognise the signs and who to report it to. One member of staff said, "Body language and how they react to people" indicated whether someone was being abused. All staff confirmed if they reported concerns then action would be taken. Senior members of staff told us they knew to liaise within the local authority safeguarding team and said, "Staff have all been made aware of speaking up". The provider had an external line to encourage staff to whistle blow and keep people safe. Staff had access to the number in each of the homes and they all knew about it.

People were supported by enough staff to meet their needs. They were responded to quickly by staff during the inspection. Most relatives were positive about the staff support their family members received. They told us, "Staff have remained constant and sensitive in regards to my brothers mental health" and, "Staff are fantastic". However, two relatives identified the recent changes had some impact on their family members. One said they were, "Concerned about care" and described a situation they had witnessed recently where no staff were present to keep their family member as safe as they would like.

Staff had some mixed opinions about the level of impact the provider changes had on people. One member of staff said, "We could lose no more staff" in the home they worked in. They were positive that three new staff had recently joined the team. Other staff told us, "Staff here are marvellous" and were positive about the team work currently occurring in all the houses. In contrast, one member of staff told us they were not happy with the changes. They said it was, "Not in the best interest of the people. Everyone was working on negative staff [numbers]" and continued, "Staff are burning out". A main concern coming from lots of staff was experienced members of staff had left who took lots of knowledge about people with them. This meant they may have not passed on important information about people who were unable to verbally communicate with new staff. It also had been identified some important relationships for people had been

lost.

The registered manager told us recruitment had been a priority for the service since the new provider took over because they were aware of staff vacancy numbers. They explained, one team manager had been seconded to help with the recruitment. When there were staff shortages the registered manager told us they used the provider's relief workers or block booked agency staff to ensure consistency. During the inspection staff confirmed this practice was happening. One member of staff said, "[Name of agency worker] is good with [name of person]. They have good relationship with [name of person]". Another staff member told us they were, "Block booking agency staff" and, "Had a couple of new starters [meaning staff] this week". They continued there was still a concern new staff were not drivers and this could have an impact on how often some people were able to access the community. The provider had a scheme where they could support new staff to learn to drive.

People were supported by a provider and manager who made improvements when there were accidents and incidents. They demonstrated how lessons had been learnt and put actions in to reduce the likelihood of reoccurrence. Staff would have a debrief with senior staff. This allowed them to reflect on what happened, receive support and learn lessons to reduce the likelihood of reoccurrence. One member of staff confirmed they had received debriefs and told us it was, "Very useful". Following one incident they had introduced a flow chart for staff to follow to ensure all the correct people and agencies were informed following an accident or incident. The provider had a 'better practice manager' who would review all the incidents and accidents to ensure management had recognised where improvements were required. One member of staff told us this helped the management identify patterns and capture themes.

Some incidents and accidents had been identified by the provider as 'never events'. For example, if a person was injured by a member of staff. If any of these events did occur there was a clear reporting system in place. It would lead to a 'never event panel' which would then identify any improvements which immediately needed to be made. This would lead to working practices changing and communicated through operational meetings. Additionally, there was a team manager's brief which contained important information including outcomes from these meetings to makes sure any learning from such events was shared to improve practice and outcomes for people.

People who displayed behaviours which could challenge themselves or others had clear plans in place to reduce their anxiety. Staff knew triggers to their anxiety escalating and how to reduce or prevent this. When people did become distressed there were systems in place to analyse and help the person manage. For example, when one person had become distressed during a specific activity the staff and behaviour support specialist analysed patterns and the events. They then identified new or known triggers for that person which led to successful participation in the future. Their care plan described clearly signs the staff member should identify if the person was anxious.

People were supported by staff who understood how to reduce the spread of infections. Staff told us when supporting people with intimate care they wore gloves and an apron. When people were unable to cope with staff wearing aprons they found alternatives to reduce the spread of infection.

In some of the homes staff were asked to work alone. The needs of the people had been assessed to ensure it was appropriate. There were risk assessments in place and an on call system should the staff need help. One member of staff told us they were lone working in the afternoon and their managers were on call. They were happy with this arrangement and knew they would get support if it was required. As well as house managers on call there was a senior manager on call system should the managers not be available.

Good

Is the service effective?

Our findings

People were supported by staff who had received training to meet most of their needs. One relative told us that most of the time members of staff were able to communicate using signing with their family member. During the inspection we saw staff understanding people's needs using the training they had received. For example, some staff used basic sign language when speaking with people. Others demonstrated how they calmed down a person who was becoming anxious.

Staff told us they were able to communicate with people because they learnt each person's signs from them. However, some staff told us they had not received any formal sign language training for a long period of time. The operations director and registered manager explained they were aware this was an area for improvement. The registered manager told us they were passionate about ensuring people had a way to communicate. They told us under the old provider there was a 'total communication' approach which focussed on developing communication around a person's individual needs. This had been nationally recognised. They continued that since the transfer this had been lost a little. The aim was to reintroduce this to ensure communication with people was adapted to their individual needs and abilities and at the forefront of all practice.

Staff told us they were experiencing a cultural change about how training was being delivered. They told us they had received lots of training both under the old provider and new provider. One member of staff said, "Previously had a lot of training" and continued to explain most of the training was online now. Another member of staff explained they received specific training in dementia recently to reflect the needs of the people they were supporting. The operations director explained they were working on finding the right balance so staff felt supported and could meet the needs of the people. One member of staff told us they had received training through online courses. They also said first aid and positive intervention training was classroom based. As a result, they felt they had enough training to meet the people they support needs.

Staff were provided with training which gave them the skills required to meet people's needs. The provider matched training to people's specific care needs to make sure people were effectively supported by staff. For example, two homes had people with diabetes and another home had a person with dementia. The staff had been provided with specific training relating to these additional needs. Some staff had been offered additional specialist training in health and social care. The registered manager said a lot of the team managers had completed a management level diploma in health and social care.

People were supported by new staff who had received a thorough induction. All staff who joined who were new to working in care were enrolled on the Care Certificate. The Care Certificate is a nationally recognised standard to make sure all staff working in care have basic skills to look after people. One member of staff was due to begin theirs on the afternoon we visited one of the homes. Records demonstrated staff who had recently joined felt supported. One member of staff had received regular reviews during their probation period including welfare checks to monitor their well-being. Other staff told us new staff work alongside more experienced staff until they feel confident enough to work alone. One senior staff member informed us they complete observations of new staff in the first three to four weeks to check they are safe to work with

people.

People who lived in the homes often had capacity to make some decisions in their life. People who had capacity were asked for their consent prior to families being spoken with by staff. One person regularly saw their family and would tell them what they had been doing. On occasions their family would be confused by what they were being told. Staff members had gained the person's consent to be able to speak with their family to clarify anything.

When there were significant decisions many people lacked capacity to make it on their own. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. One member of staff said, "You have to make sure they understand" when assessing whether someone has capacity to make a decision. They told us they would consider other options to ensure the least restrictive options were chosen for people.

We checked whether the service was working within the principles of the MCA and found people who lacked capacity to make important decisions had them made in line with current legislation. For example, one person could become distressed about going to hospital. A discussion was had with their GP and relatives to ensure medicines being used were appropriate, in their best interests and least restrictive. Other people who lacked capacity had decisions made demonstrating the least restrictive options were opted for and there was consultation with others including relatives and health and social care professionals. For example, one person had been assessed as lacking capacity for a specific decision of accessing the community alone. This was to ensure they were kept safe. Through discussions with other health and social care professionals and family the least restrictive option was put in place which did not impact others. This was a system which alerted staff to someone leaving the building so they could check who it was. There were occasions when the use of an advocate had not been considered An advocate is an independent person who represents the voice and interests of people who have difficulty expressing their own opinions. Some of the team managers were able to identify people this could be an option for. Although people did not have any representatives available to support them and make sure their views were heard.

People were supported by staff who worked with other health professionals and families to maintain their health. One member of staff told us people with specific health conditions such as diabetes had regular health checks. This included eye checks at the hospital and regular blood tests at their GPs. Another person was picked up by their relative to go home and one member of staff gave detailed information about the person's health condition. This meant the relative was aware of what they needed to do to ensure the person's health did not decline. Another member of staff told us about the work they had done with a speech and language therapist to help someone improve how they communicate their likes and needs to staff. This led to one person having an electronic tablet with a specific application on it they could select information they wanted to communicate.

People had been supported to see a range of health professionals to ensure their needs were met. One person told us their relative and staff took them to the doctor when they were not feeling well. Another person signed to us they were going to hospital next week in a taxi. One relative said, "They [meaning the staff] take her to the doctors and dentist". One person's records demonstrated they had recently seen a podiatrist, optician and specialist for a health condition. When people's health declined they were referred to a doctor or specialists. For example, one person with epilepsy had recently had an increase in seizures. Staff had immediately made contact with their doctor and specialist nurse who were reviewing their

medication in line with the changes. Staff were monitoring the impact these changes had so they could work with the health professionals to improve the person's health. Another person with diabetes had moved to their home from a placement where their blood sugar had not been appropriately managed. Since moving into their current home staff had managed to stabilise this and were commended by the specialist health professional who reviewed the person every six months.

People's care plans reflected and celebrated their differences. They gave guidance to staff about how to adapt their interactions in line with these. For example, one person's plan gave clear instructions to staff about speaking in front of the person using a clear loud voice so they could lip read and help them hear. Staff knew about this guidance and we saw them following it. The person was smiling and laughing with the members of staff.

Each person had health action plans in line with current national guidance. This included a 'health pen picture' which provided key information for when they transferred to hospital including the medicines they were on. One person's had some pictorial entries to make it more accessible for them to access.

People were supported to eat a range of food and healthy eating was promoted. Some people had a weekly takeaway during the inspection. They had become very excited prior to it being ordered and were asked what they would like. Other people chose to eat salad and bread for their lunch. One relative said their family was offered, "A weekly meal choice and encouraged a balance diet". Staff understood the importance of providing a mixture of meals for people. They felt it was important to involve people in preparing their food whenever it was possible.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. One person listed staff names saying they were all, "Lovely". They then had a joke with the staff about whether they deserved to be paid for the work they had done. They said, "As long as she looks after me" they could get paid. Another person nodded and smiled when we asked them if they liked the staff. One relative told us the care their family member received was, "As good as anywhere and he is well looked after". Another relative said they were, "Extremely happy, completely marvellous, experienced care". One member of staff said, "They [meaning the people] are well looked after in the circumstances [meaning the provider change]". Another staff member told us, "We are all proud of ourselves, of the job we have done, through the very difficult circumstances" and continued to explain about the caring support they provided for people. They said, "It has not had a detrimental effect on the people". The registered manager told us, "We always strive to do a good job. Putting people at the heart of what we do".

During the inspection it was clear all staff cared deeply about the people they supported. One person smiled and signed "Happy" to us when they were asked if they liked living in their home. One staff member told us they had, "Focussed on the care". Another member of staff said, "It is lovely working here" and spoke fondly about all the people they supported. Staff knew people very well and all interactions with them were positive and caring. People appeared comfortable and relaxed in the presence of staff. On occasions people would give members of staff cuddles to greet them and make jokes about the staff.

People had experienced a large amount of change in staff in a short space of time. The management and all staff were clear although there was uncertainty, they all put people and their needs first. One staff member said, "There were big relationship losses. Lost six staff". They continued, "We remain as consistent as possible" to help people through the change. Another member of staff said, "Staff have been very demoralised" about the changes which have occurred. They continued to tell us they, "Do our best. Do not want it impacting upon them [meaning the people]". However, there were occasions when the emotional impact of this had not always been considered by staff. One team manager told us they will look into further support for the people in their home.

People were supported by staff who knew how to respect their privacy and dignity. They had the choice to secure their bedrooms within the houses. For example, one person with capacity had a key for their bedroom door so they could lock it when out. Another person had a bedsit with a door bell and lock on the bedroom door. Relatives told us, "The staff respect his dignity and knock on the door before they enter" and, "They always knock on his door. If he says go away, they will go away and then try five minutes later".

In one home there had been an issue with people letting themselves into a bathroom whilst someone was having a bath. To reduce this happening and protect the dignity of the person having a bath an additional lock to the door was added. Another person had a condition which meant for safety they could not be left on their own in the bath. Staff knew to respect their privacy. They told us they would wait around the corner and monitor closely from a distance. All staff promoted people's independence when they were supporting them with intimate care. They knew to take people's clothes in the shared bathrooms and get them dressed

before they left.

People were supported to stay in touch with family and friends. One person had made a friend in another service and the staff supported the friendship to develop. One relative said, "The staff help him video chat with family which he enjoys". One member of staff told us they encouraged family involvement when it was appropriate. They said, "People's family come regularly" and told us one person spoke regularly to a family member who was overseas. They were currently looking into ways to improve this contact through internet video links.

Most people's spiritual and cultural needs were considered and respected by staff. One relative did say since the change in provider their family member had not attended church. One member of staff told us they supported a person to attend church on Christmas day and described how happy the person was. Another person's care plan identified the religion they choose to follow and support they would like from staff to achieve this.

People were encouraged to make choices about their care and support they received and staff respected their preferences. One person had picture cards and used a form of sign language to express their views. One relative told us their family member had, "A degree of choice. Everything is centred on what he wants to do". Staff explained some of the time they knew people's preferences because they, "Vote with their feet". This meant when they were not happy they would walk off or not engage. Another staff member told us they used a range of ways to encourage people to make choices. This included objects of reference which people could point to, pictures and basic signing. One person chose their clothes before staff supported them with intimate care. When the person was feeling unwell the staff member gave the option of pyjamas or day clothes. The person chose their pyjamas and going back to bed. This was respected.

Good

Is the service responsive?

Our findings

Peoples care plans were personalised and considered their needs and wishes. Staff were familiar with them and knew about people's personal preferences. One member of staff told us they were, "Customer led". This was important because some people had limited verbal communication. One person's care plan gave a list of their favourite hobbies and outlined what a good day looked like for them. It then gave information about what a bad day would look like and how staff could help them achieve more good days. Staff knew a range of strategies to help involve people in planning their care and support. This included visual choice mats, likes and dislike boards and visual books with pictures which could be pointed at. However, staff told us they had not involved some people as much as they could in their care plans. They came up with ideas of how this could be improved during the inspection.

People who required support with specific activities such as intimate care had clear guidelines in place for staff to follow. For example, one person's care plan said, "[Name of person] will need support from staff to ensure he has completely dried himself". All staff were aware of this person's care which meant there was consistent support.

People's care plans contained important information such as their background and life story. This was important because some people receiving support had limited verbal communication. It provided staff with talking points and demonstrated they understood what was important for the person. Some people had pictorial life histories which included records of their family members and previous holidays. One member of staff told us this provided opportunities for people to recall important events in a format they understood. They said, "[Name of person] loves recalling those memories". One person's care plan contained information about their family and where they were born. Other people's had details about their hobbies and interests. This was then reflected throughout the activities they participated in and their home. For example, one person liked water so went swimming and had an area in the garden they could play with water.

People had care plans which were personalised with activities and strategies to help them gain further independent skills. For example, one person struggled to prepare their own meals in the house because it was too noisy and busy. Staff had identified by taking them to a different location which was quiet they could learn to cook. As a result, the person was able to cook on a regular basis to develop their independence.

People's care plans were reviewed; some more regularly than others. People had monthly meetings with key members of staff so they could discuss their aspirations and set themselves goals. If appropriate, these were then shared with the person's family so everyone important to them could support their progress. One person had annual reviews recorded which included their input as much as possible. Another person told us they had been involved in reviews of their care. When changes were requested these had been respected. For example, one person asked for their room to be decorated and this had been completed. Consideration had been made about the colours. On the occasions when reviews had not been as frequent staff explained the people's support was always put first before their paperwork so had completed them verbally but not

recorded them.

Activities reflected people's needs and interests outlined in their care plans. During the inspection, one person had gone out to the Turkish barber; one member of staff told us the person liked being pampered and enjoyed the massage. One relative explained there had been a change in their family member's needs. In response staff had adapted the activities they did. They said staff did, "Appropriate activities for him" and, "Take him out every day for fresh air". Another relative said, "Staff understand his differences and offer places to go and things to do and respect his decision". However, some relatives did inform us since the change in provider their family member had not participated in as many activities. They explained this was down to staff leaving. We saw the registered manager and staff were working hard to prevent this from being a long term problem by having proactive recruitment plans.

People were encouraged to be active members in their community. In one home, everyone went for a drink at a local coffee shop every morning. When we spoke about this with people they smiled and laughed with us about it. One member of staff knew a person liked going swimming. They knew they had to consider how busy the swimming pool was to reduce the anxiety for the person. When people had difficulties accessing the community because of their disability staff had found other ways for them to maintain independence. For example, one person was too anxious to leave their flat regularly so they completed their weekly shopping online.

We discussed with the registered manager and team managers how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. They had begun working on ensuring information was adapted to be accessible by everyone. For example, one person had a visual daily schedule which helped them navigate through their day. Another person had a visual timetable to provide structure for their week. Other people were involved in the planning of their care so their needs and wishes could be reflected in their care plan. Members of the management were aware there were still things they could do to make care plans more accessible. The registered manager and some team managers informed us they were introducing new electronic care plans. They would consider making parts of the care plan accessible to people at their level of understanding.

People and their relatives knew who to complain to and told us they were listened to. One person knew to speak to their family if they were upset. They told us their relative then sorts things out. Other people had close relationships with staff members and knew who they could speak with. One relative told us, "The staff resolve problems and I'm happy with the care". There was a robust complaint system in place to manage formal complaints. The registered manager showed us the new electronic system which improved people receiving a timely response. They told us since the change in provider they had been encouraged to be open and transparent with relatives and people who use the service.

People had not always had their end of life needs considered. The staff and registered manager explained this was because most people using the service were younger. The operations director told us the provider had recognised this was an area for improvement. The provider was in the process of ensuring people received a dignified death. Two members of staff had been trained in the Gold Standards Framework. This is a standard which aims to optimise support for all people approaching the end of their life in care settings. The members of staff were making connections with the local hospice. The operations director and registered manager would be ensuring the training and practice would be rolled out to all the homes.

Good

Is the service well-led?

Our findings

People were supported by staff who had a clear line of accountability. Each home was overseen by a team manager who was supported by an assistant team manager, team leaders and senior support workers. All team managers were supported by the registered manager. A performance coach had recently been employed by the provider to work alongside the registered manager and provide additional support. The registered manager was positive about the support they received from the provider including the operations director and access to other specialist professionals such as human resources and a quality lead.

People had positive relationships with the management in each home. This included having good interactions with them and smiling when they came in the room. Most relatives were positive about the communication they received from senior staff. One relative said, "The manager [of the home] is very good". Whilst others said, "I can call the manager whenever I like" and told us about systems of a communication book in place. There were occasions when some relatives felt the management of their family members' home were not as available as they liked. As a result, sometimes they felt communication had not been as good.

Staff spoke highly about the management of the homes. One member of staff said, "Never left us to flounder. They [meaning the management] listen when we shout" when they had raised issues. Other staff told us, "[Names of assistant team manager] is wonderful. And [name of team manager]" and, "[Name of team manager] is always at the end of a phone".

Staff spoke highly about the registered manager. One member of staff said, "I have seen [name of registered manager] when she did a service report. Always at end of phone if [name of team manager] is not available". Another member of staff told us they felt supported and went on to describe how the registered manager achieved this. They said, "She [meaning the registered manager] is on the phone". When they required support staff informed us the registered manager was always available. One member of staff told us, "[Name of registered manager] is very supportive. Do not see her frequently. If I need to rant, [Name of registered manager] will always answer her phone. She is always available".

The provider promoted an open, honest and transparent culture to ensure people were receiving high quality care. One member of staff told us, "The office door is always open. Colleagues can be a sounding board. Team wise could not have done any more to support". The registered manager told us since the current provider had taken over the service there had been a drive for this culture. This included looking at lessons learnt following incidents and accidents. Staff in the home were aware of this change and ensured it was reflected. During the inspection people were free to walk around their homes and would regularly enter the offices to speak with staff. Staff always welcomed people and spent time finding out the reason for their visit. Staff told us, "The door is always open" and, "We have open door policy if anyone wants a chat".

People were supported by a service where there were clear lines of communication which helped to ensure their needs were met in a safe and effective manner. There were a range of meetings where information could be shared throughout the organisation. Additionally, team managers were sent a brief regularly which

contained changes to any policies and procedures. One senior member of staff told us they, "Can ask other managers with experience of certain things" when they need help. They were positive about the support they got through this system. Throughout the homes there were monthly meetings to share information raised at the management meetings. One member of staff said, "The staff team are very supportive of each other". Another member of staff said there were monthly team meetings and they had a, "Network of colleagues".

People were supported by a provider who had a system to monitor the quality and committed to on-going improvement to people's care and support. Recently, the provider had completed an assessment of each of the supported living homes in the service. Following this they produced an action plan which was overseen by the performance coach and registered manager. The performance coach told us they visited each home every month and supported the team manager with the improvements. The registered manager completed a quality audit each month to identify progress against the action plan. They also completed each team manager's supervision to provide further support and drive improvement.

The provider had plans to work with an external partner to continue to drive improvements in the service. The operations director told us they wanted to provide an additional layer of scrutiny to the quality of service people received. Some of the things they were going to focus on were people's choice and control, health and employment opportunities. Another of their roles was to promote greater community presence.

The provider was aware the supported living services and staff were facing a lot of change. Therefore, they had created an action plan of when changes were going to be introduced in a phased way. This was to ensure there was a drive to high quality care whilst respecting the need for people and staff to adapt. One of the improvements they were going to make was introducing a new way of care planning. The registered manager told us it was an approach which would put the person at the centre of their care. It would focus on outcomes for people and identify goals and aspirations they would work towards with staff support. They had already begun to introduce a scheme around medicine management. This was to promote the reduction of the amount of medicine people were reliant upon when using the service. Staff we spoke with were aware of the new medicine initiative.

People and their relatives were encouraged to contribute their ideas to help improve the service. The provider ran parent and carer surveys as a way of hearing what was going well and what could be improved. They responded to these by reviewing support people were receiving. They also had set up involvement and engagement forums as another way people and their relatives could get involved. Through this they would run listening events and test out new ideas which could be commented upon. The provider included relatives and people on their own Board of Trustees. This was to ensure the people's views and voice were captured at all levels.

The management were constantly striving to improve the service they provided for people. One team leader told us they wanted to increase the photographic evidence they recorded for people. They explained recently a person had attended a concert after choosing not to go out very often. Unfortunately, they had not recorded this event photographically so it would be more difficult to reflect with the person on their positive experience. They said by taking photographs in future it would provide a discussion point with the person.

The registered manager and provider were aware of when notifications should be sent in line with current legislation. There had been notifications received in line with statutory requirements to inform the Care Quality Commission (CQC) when people had been hurt or there was a death. However, they had not informed us of some notifiable incidents. Staff had liaised with other health and social care professionals,

the person and their relatives to reduce the likelihood of this happening again. By not notifying CQC external monitoring was unable to be completed. The registered manager showed us a new system which was now in place to monitor all incidents. This would highlight if appropriate action had been taken including sending notifications to external parties such as CQC. Following the inspection they sent retrospective notifications to ensure they were up to date.