BMBC Services Limited

Barnsley MBC Learning Disabilities-Domiciliary Care Team

Inspection report

Beevor Court
Pontefract Road
Barnsley
South Yorkshire
S71 1HG

Tel: 01226775389

Date of inspection visit:
20 September 2016
28 September 2016

Date of publication:
20 December 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was announced and took place on 20 and 28 September 2016. The service was last inspected in July 2014 where the provider was found to be complying with all relevant regulations at that time.

Barnsley MBC Learning Disability Services is a supported living service which provides care and support for people with learning disabilities. Care is provided to people in their own homes via tenancy agreements. At the time of this inspection the service provided care to approximately 50 people, some of whom lived on their own, whilst others were accommodated in shared houses.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe when supported by staff employed by the service. All staff members had been trained in recognising the signs of potential abuse and how to respond. A safeguarding policy was in place and records showed staff had been proactive in referring any historic concerns to the local safeguarding team.

Risks had been assessed and re-evaluated regularly. People were encouraged and supported to be as independent as they could be, and risks related to independent living had been assessed and mitigating actions identified. Accidents and incidents had been monitored and measures put in place to reduce the likelihood of them reoccurring.

There were enough staff to meet people's needs. Processes were in place to ensure any staff absences could be covered so people still received their scheduled visits. Robust recruitment procedures had been followed.

Staff had undertaken training in a range of subjects through both online e-learning and face to face practical training. Staff training was monitored to ensure any required updates or refresher training was received on time, so staff skills and knowledge remained up to date. Staff received additional training in relation to people's specific needs, and their skills were assessed to determine if they were competent to deliver tasks safely.

Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. We found the provider was complying with their legal requirements. The manager and staff were able to describe how the principles of MCA were adhered to in daily practice.

People's nutritional needs had been assessed and specific information provided about how to meet these needs. Food and fluid intake was monitored where necessary. Records showed people's likes were taken into consideration and that people were involved in choosing and making their own food.

People we spoke with told us they were happy with the care they received. They told us care was planned around their choices and that staff listened to them.

People's needs had been assessed and specific and detailed care plans had been created to ensure all staff had access to information about people's needs.

People were encouraged to share their feedback. We saw very positive responses had been received following a survey of people and their relatives in September 2015. The results had been collated and analysed and the responses indicated people were satisfied with the care they received.

The service had received one complaint in the 12 months prior to our inspection and this complaint had been investigated and responded to appropriately and in line with the provider's complaints policy.

People and their relative's told us the service was managed very well. The manager shared with us their vision for the culture of the service, which was to develop people's independence and enable them to enjoy full lives. All of the staff we spoke with told us they agreed this culture was in place.

Staff told us they felt listened to and valued. Staff meetings were held regularly. Their feedback had been sought through a staff survey.

A range of checks were carried out to monitor the quality of the service. Care records were maintained to a good standard and stored securely so they remained confidential.

The manager told us the service was due to cease operation in April 2017. Processes had been put in place to minimise disruption to people who used the service and staff during the transition to new providers.

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.

The safeguarding policy was followed, and safe recruitment procedures in place to minimise the risk of abuse.

Risks were assessed and mitigating actions identified to enable people to develop their independence whilst minimising risks.

Processes were in place to ensure medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

The service was operating within the principles of the Mental Capacity Act. People's capacity to make decisions had been assessed and where appropriate 'best interests' decisions were made.

Staff training, supervision and appraisal were up to date to ensure staff had the skills and knowledge to meet people's needs

People were supported to access health professionals when required.

Is the service caring?

Good

The service was caring.

Staff knew people and their needs well. We observed people were relaxed around staff, and interactions were positive.

People were encouraged to be independent and to work towards personal goals.

People were invited to attend a 'tenants group' to share their views on the service and to meet up with other people in a social setting.

Is the service responsive?

Good

The service was responsive.

Assessments and care plans were person-centred and specific

People were supported to take pursue their hobbies and take part in activities.

A complaints procedure was in place. We saw complaints had been dealt with in line with this procedure.

Is the service well-led?

Good

The service was well-led.

There was a system of quality assurance in place, to monitor and improve the service.

A registered manager was in post, people spoke highly of her and the way the service was run.

Staff told us they felt well supported and relatives told us they had no concerns about the quality of the service.

Barnsley MBC Learning Disabilities-Domiciliary Care Team

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 20 and 28 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be available in the office to assist us. The inspection was carried out by one inspector and took place at the office base for the service.

We looked at the care and support records of four people who used the service. We looked at records related to the management of the service, such as audits, staff files and recruitment records. We also reviewed information we held about the service including any statutory notifications that the provider had sent us. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

During the inspection we met with four people who used the service. They visited the office and spoke with us about their views of the care they received. Following the inspection we also telephoned four people's relatives to discuss their views. We spoke with the registered manager, two customer relations managers and four care workers. We were sent information following the inspection to support us with our enquiries.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe when in receipt of care from staff. One person said, "Very nice. All the staff are good." People told us they would talk to staff if they had any worries or concerns. One person told us, "I could talk to [staff name] about anything." Relatives told us the care their family member received was safe. One relative said, "Yes I do feel he is safe, very much so. They err on the side of caution and have plans in place for every eventuality."

There were safeguarding policies and procedures in place to ensure staff were aware of how to respond to any concerns that people were subject to harm or abuse. All staff received training in the different types of abuse and potential indicators. Staff we spoke with were aware of their responsibilities and told us they would not hesitate to report any concerns to their manager. We reviewed historic safeguarding records and saw the service had shared information with the local authority safeguarding team in a timely manner when staff had recognised that one person was at risk of abuse.

Assessments had been carried out to determine the level of support people required with their finances. Where purchases were made on people's behalf, such as buying groceries, staff recorded the information and retained receipts. Finance checks were carried out monthly by senior staff to ensure receipts had been recorded and monies had been handled appropriately. This meant arrangements were in place to minimise the risk of people being financially abused.

Assessments had been carried out to identify any risks to the person using the service and to the staff supporting them. These included environmental risks as well as those related to people's needs, such as taking prescribed medicines, moving and handling or accessing the community. Where risks had been identified, instructions had been provided for staff about the steps they should take to mitigate those risks. The manager explained that the purpose of the service was to enrich people's lives and to develop their independence so risks were not necessarily avoided. For example, one person was working towards travelling independently. We saw steps had been taken, and risks assessed to enable the person to do this. Initially the person was accompanied to the bus stop by staff and then met at their destination stop. Once they became confident with this, staff reduced their involvement and only met the person at their destination. We saw as the person had developed their independence skills, their risk assessment and care plans had been updated accordingly. Accidents and incidents were recorded and monitored and appropriate action had been taken, where necessary, to reduce the likelihood of accidents reoccurring.

People and their relatives told us the service was very reliable. One person said, "They always come on time, when they say they will." Staff carried devices which they used to 'check in' when they arrived at people's homes. If staff did not 'check in' to scheduled visit within 15 minutes of the appointment time, then the service was alerted and the staff member was contacted. The manager told us the device ensured they never missed a visit; as if the scheduled staff member had not attended they could arrange emergency cover so people were supported. The device enabled the service to monitor punctuality and was a tool to reduce the risks of lone working, as staff also 'checked out' of visits.

There were enough staff to meet people's needs. Staffing levels were appropriate to the number of people using the service at the time of our inspection and the level of their needs. Staff were organised into team groups who visited each person. This provided continuity of care. The registered manager told us that any unexpected staff shortage would be covered the on-call team. This meant people would always receive their planned visits and care from the service.

A recruitment policy had been followed to ensure people were supported by staff with the skills and experience to meet their needs. Each staff member had submitted an application form, attended an interview and was subject to two references before they started working for the service. Applications had been made to the Disclosure and Barring Service (DBS) to determine if potential employees had a criminal record or were barred from working with vulnerable people. Safeguards had been built into the recruitment system in that until these checks had been recorded as complete, the employment contract could not be progressed.

Staff had received training in the safe handling of medicines and undertook annual medicines competency assessments to ensure their skills and knowledge were up to date. Where people were supported with their medicines, clear instructions detailed the levels of support that staff should give each person in respect of their medicines. Care plans stated what medicines had been prescribed and how they should be taken. Where people had been prescribed 'as required' medicines instructions were provided for staff about what the medicines were for and the circumstances in which they should be given. For example, one person was prescribed 'as required' epilepsy medicines to be given if they had a seizure(s). The care plan detailed specifically how many minutes staff should wait before administering the medicines and at what point staff should call for medical assistance if the seizure(s) continued. We spoke with staff who supported this person. They were aware of this plan of care and could talk us through the steps they would take to support them during a seizure or multiple seizures. This meant processes were in place so that medicines were managed appropriately.

Good

Is the service effective?

Our findings

People we spoke with told us they were happy with the support they received from staff. One person said, "My staff who look after me are good. They do whatever I need." A relative told us they thought staff were well trained, they said, "They have a lot of training. They seem very able, very competent."

Staff training information showed staff had received training which was essential to their roles. All staff had undertaken training in safeguarding adults from abuse, moving and handling, positive behaviour management and physical interventions, emergency first aid and mental capacity. In addition to this, some staff had undertaken specialist training to meet people's individual needs. For example, all staff who supported one person with epilepsy had undertaken epilepsy awareness training. One staff member told us they had attended training delivered by the challenging behaviour team, specifically designed for one person who used the service.

Staff training needs were monitored by administrative staff who arranged training updates as they were required. Staff we spoke with told us they felt they had been given appropriate training for their roles. One staff member said, "The training is sufficient. You get sent on all the courses and do all the training that you can for a job like this. There is always an element of learning on the job, especially when people have complex needs, as you need to get to know them, but the training is enough to give you a good understanding."

New employees completed a 12 week induction. This induction period included online and practical training, and working towards the Care Certificate in health and social care. The Care Certificate is a set of standards designed for health and social care staff. Records showed that during their 12 week induction, staff were asked to reflect on their learning and skill sets, and their competencies in a range of areas were assessed.

New staff shadowed experienced care workers before they were able to work on their own. Staff told us that whenever any new or experienced staff member started supporting a person they had not worked with before, they shadowed other staff who knew that person and their needs well. One staff member said, "You are never sent in blind. You will always shadow other staff. It's important for the staff member so they know they know everything they need to, but also for the client. It means they can be properly introduced by staff they are comfortable with."

Staff had regular opportunities to discuss their practice, their role and the needs of the people they supported. Individual supervision session records showed staff were asked to reflect on the care they delivered and to discuss any areas for development. Staff also attended team group meetings where staff who supported the same people came together to discuss what was working well and what could be improved.

Staff competency was assessed and conduct was observed at spot checks which were undertaken in people's homes. Annual appraisals were held where staff were asked to consider their performance in the

previous year and to discuss any personal development needs. Staff we spoke with confirmed they regularly had contact with their supervisor or manager, and that they had opportunities for personal development. One staff member said, "It's all very supportive. If you have any issues you can call up and request a meeting. It would be arranged straight away."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager and staff were aware of the processes to follow where people did not have the capacity to make their own decisions. Some people who used the service did require constant support to keep them safe. The registered manager was aware that the deprivation of liberty standard authorisation process was not applicable within the supported living environment, as people were tenants in their own home. An application to the Court of Protection had been made for one person for the authority to restrict their liberties in their best interests. At the time of our visit the authorisation was awaiting consideration by the Court of Protection. The manager advised us that following advice from their legal team, once this test case had been decided, other applications would be made.

Staff we spoke with were aware of the principles of the MCA and were able to describe examples where it had been applied. Staff told us they had concerns over one person's partner. Following a mental capacity assessment it was determined the person did have the capacity to decide if they wanted to remain in their relationship, and staff described how they offered support whilst respecting their decision. Relatives we spoke with told us they had attended 'best interests' meetings with staff from the service. One relative said, "The staff are very good, they know [my relative] very well. They advocated for him at a meeting with the council. They really try their best for the people they support."

People were supported to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. We saw evidence in people's care records of input from GPs, specialist nurses such as the epilepsy nurse team, dentists, opticians, occupational therapists and the behavioural input team. Where information had been provided by healthcare professionals, this had been noted within care plans, and key information had been provided for staff. For example, we saw one person's health needs included details from the optician, it
said, "I have limited eye sight, I tend to look out of the corner of my eyes." The record included the name of the person's optician, and the prescription of the glasses they wore. It set out to staff why it was important that they were worn. Records stated, "These help me to see images clearer and will enable me to judge the space between the pavement edges and the road more easily."

People we spoke with told us staff attended their appointments with them. One person said, "Staff take me to the doctors." Another person told us, "I normally go to the doctors by myself as I can get there by myself on the bus. They will come with me if I'm going to the hospital though." Relatives told us they thought people's health needs were managed well. One relative said, "They watch out if things aren't right and they'll contact who they need to. If they aren't sure if [my relative] is acting like themselves, then they will get an appointment with a GP or get the emergency doctor out. There have been times when they had ambulance out and taken them to A&E."

People's food and hydration needs had been assessed. We saw information within people's care plans which showed people's preferences had been taken into consideration. Records included information about people's likes and dislikes. One person's care plan described how staff were supporting them to attend a weight management group. Another person's care plan showed that staff were supporting the person to become more independent in preparing their own food using vegetables they had grown in their allotment.

Good

Is the service caring?

Our findings

People we spoke with told us they were very happy with the service. One person said, "I love [name of care worker]" and another person told us, "The staff are lovely."

On the second day of our inspection, four of the people who used the service came into the office to speak with us. They were accompanied by staff, and we saw people and staff enjoyed a comfortable and relaxed relationship. One person told us about some of their hobbies and frequently included their care worker in the discussion. For example, they said, "I like to go to parties, don't I [name of care worker]?" The person was smiling throughout their conversation with us. We saw their care worker responded to the person's prompts to join our discussion and that they knew the person well. They reminded them of the name of the person hosting the party, what gift they had taken, and that their favourite songs had been playing.

Relatives told us the service and staff were very caring. One relative said, "I'm 110% happy, I couldn't praise it enough." Relatives told us staff knew their family member well. One person said, "They've all got to know [my relative]. They know [my relative]'s quirky ways and they'll respond to them. That's really important to me."

We spoke with four care workers, who told us they enjoyed their job and were proud of the work they did. One staff member said, "I honestly think that we do an outstanding job. People come on so much when we start working with them. We are really making a difference to their lives." Staff told us they felt the organisation encouraged them to put themselves in the mind-set of the people they cared for, so they could do as much as they could to enrich people's lives. One staff member told us about a party they had planned for one person's milestone birthday. They said, "We'll always do as much as we can to celebrate events for people. Not everyone has family around them, so we make sure birthdays are celebrated. It was [name of person]'s birthday recently and we organised a big party. We invited their friends from the day service and the people they know from our events. Everyone helped out. Some of the staff even came along on their day off so that there was a big crowd."

We saw the service had received positive feedback from people who used the service and their relatives through thank you cards and responses to a satisfaction questionnaire. We reviewed the most recent results of the questionnaire, which had been distributed in September 2015 and saw all of the responses regarding staff were positive. Statements such as; 'The person supporting me has time for me', 'The person supporting me gives me the help I need when I need it.', 'The person supporting me listens to what I have to say' and 'The person supporting me respects my privacy', had all been answered with 100% satisfaction.

People were included in planning their care. Their views and preferences had been recorded throughout their care records. Care plans contained information about people's family life, hobbies and needs. They had been written from the person's point of view, for example one person's care plan stated, "I prefer to shower in the evening", another said, "I can make a choice of what I want to wear" and a care plan related to a person's finances stated, "I am my own appointee, but I need support to deal with all of my finances, especially correspondence. I need to keep my taxi/travel fairs separate to my spends, as I easily become

confused with money." This information supported staff's understanding of people's needs and preferences.

Care had been planned in a way which respected people's right to privacy. For example one person's care plan described the way staff should gain entry to their home, whilst considering their dignity and independence. Staff were instructed to ring the doorbell, and if there was no response try again after ten minutes had passed, then telephone their landline, and only if there was still no response were staff instructed to enter the person's home using their key. People we spoke with confirmed that staff were respectful to them and their homes. This showed people's privacy and dignity was promoted.

The manager told us they referred people to advocacy services if they felt they needed support to make decisions. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. We saw from records two people had been referred to advocacy services within the previous 12 months.

Discussion with the staff revealed there were no people using the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw assessments within people's care records which prompted staff to consider whether any arrangements needed to be made to ensure people's cultural and diverse needs were taken into account. A cultural awareness guide had been provided to staff, with information about people's culture. For example, the section on Sikh religion, included information about ways of dress, diet, language and local information such as maps showing places of worship. This meant staff had been provided with information to help them understand and support people's cultural and religious needs.

Staff told us that the care planned and delivered, was designed with input from people. One staff member said, "Sometimes people can't communicate in words what it is that they want, but we know people so well that we can work out what they will enjoy." Staff and the registered manager, gave us lots of examples of where they felt they had gone 'the extra mile' to enrich people's lives. Staff told us one person had always wanted to get a dog, and staff had recently supported them to do so, helping them to register with the vet and to purchase the items they would need to look after the dog. Staff told us when this person had been unwell recently and therefore unable to walk the dog, the manager took it home with her, to look after it until the person was feeling better.

The manager told us that one of the main aims of the service was to develop people's independence. We saw from people's care records that goals were identified for them to work towards, and their progress against these goals was regularly updated. For example, people were supported to make their own meals, initially working with staff to prepare food, before independently preparing food whilst staff were available to support them if needed. People we spoke with confirmed they were more independent since using the service. One person said, "I can get the bus now by myself. I used to need staff, but I'm fine now." A relative said, "We've just had a review. We discussed trying to make [my relative] more and more independent. [My relative] is doing more things for them self, [my relative] is going to have some adaptations to their house, that's all coming from the service. I've always encouraged independence but they have got [my relative] doing so much more; they even open and close their own curtains now." This demonstrated that people were supported to develop and maintain their independence.

Information had been provided for people in an 'easy read' format, which included images and the use of simple language, to meet people's needs. Information presented in an 'easy read' format included details about the service, what people should expect from the service and details about what people should do if they had any complaints. Information had also been presented in this way for certain medical interventions, such as cervical screening or blood tests. Staff told us they used these 'easy read' guides to talk people

through what would happen, and why, if they were attending GP or hospital appointments.

The service ran a 'tenants forum meeting' every second month. Everyone who used the service was invited to these meetings, and transport was arranged for people who needed it. We saw from the posters advertising the meetings that in addition to giving people an opportunity to discuss the care they received, they were also social gatherings. On occasions guest speakers were invited, and activities such as bingo were facilitated for people to enjoy. One of the people who used the service loved music and put on a disco at each of the tenants meeting. The manager explained, "The tenants meetings are great. We'll ask them (people) some questions, make sure everyone is happy, but most of the time people just want to get on with the bingo or the disco! Some of the people we support don't go to day centres so it's a great opportunity to meet up with their friends and get to know new people. If it coincides with someone's birthday we'll put a buffet on too, and that always goes down brilliantly."

Good

Is the service responsive?

Our findings

People and their relatives told us that their needs were well met by the service. One person said, "They do everything I need." A relative told us, "Staff know [my relative]'s needs well. I would like it to continue at the quality it is at the moment."

We looked at four people's care records; they were detailed, very specific and gave a good overview of people's individual needs and how they required assistance. A range of assessments had been carried out to determine people's individual needs. We saw assessments had been updated and re-written when people's needs had changed. This meant people's care was monitored to ensure it was appropriate to their needs.

Assessments were used to determine what level of support people needed from staff, assessments included mobility, personal hygiene, nutrition and health needs. The care plans were detailed and provided clear guidance for staff about how to support each person with their needs. We saw guidance had been provided in a number of different ways so staff had access to as much information as possible about how to support people. For example, one person had complex communication needs and we saw their care plan was very detailed. It included the specific facial expressions and actions the person used to communicate their wishes. For instance, it stated, "When [name of person] is asked a question, they tend to nod at the first statement said to them. Staff to check by offering a choice of two options, i.e. tea or coffee. If they do not want the item they will push it away." It continued, "[Name of person] indicates which direction to go in by pushing the frame in that direction and walking towards it. They will stop still and refuse to move if they want to sit in their wheelchair."

A video was also available for staff to watch, to help them to understand this person. The principles of the MCA 2005 had been followed in relation to the creation of this video, and processes were in place to ensure that it was stored securely. Staff told us this video enabled them to learn about the way they would need to communicate with the person before they supported them, and it equipped them with the skills they needed to meet the person's needs and provide continuity of care.

People's care needs and plans of care were reviewed on a regular basis. People and their relatives were included in reviews and their comments and feedback had been recorded.

Staff told us the service was responsive to people's needs and preferences. The number of hours people received care could vary from week to week, to accommodate people's requests. For example, one person had received more hours than their usual package of care in one weekend, as they had been accompanied by staff to visit Blackpool to attend an event that they were interested in.

People who used the service, their relatives and staff all told us care was delivered by a small team of staff who knew people's needs well. One relative said, "[my relative] has a team of 5 (staff) to look after them as their needs are very complicated. It's always one of those staff members who provides the care and that's very important. When staff are on holiday or sick it isn't ideal, but the staff work extra shifts to cover it, as they (person) have to have staff that know them." Another relative said, "It's always someone they know who

provides the care. It's consistent which [my relative] likes. They like to know who is coming too so staff will write that in the diary." This meant care was provided by staff who knew people's needs and preferences well.

People had been asked to share their experiences of the service. Satisfaction surveys had been sent to people who used the service in September 2015. We viewed the individual responses and analysis of results. Responses were very positive and actions had been identified to improve the service further. We noted the analysis of the survey included lots of graphs and had not been presented in an 'easy read' format. The manager acknowledged this and advised us that in previous years she had designed specific feedback for people who used the service, but this year due to additional demands on her time she had not been able to do this.

Complaints records were well maintained. We saw one complaint had been made in the 12 months prior to our inspection. The original communication had been recorded, investigations had been carried out and the person who had complained had been kept up to date with the progress of investigations and the outcome.

Recent changes meant people would receive their care in the future from another provider. The service was working alongside other providers to ensure the transition was well planned and managed. The registered manager told us that some people who had increased their independence whilst using the service had already moved their care to other providers. They told us they worked closely within the new provider, and offered opportunities for new provider's staff to shadow their staff whilst they supported people. The service had a checklist for handover to new providers to ensure all relevant information was available, so the process could be as smooth as possible for people using the service.

People who used the service had different packages of care, determined by their needs. Some people had limited recreation as part of their 'care package', whilst other people received more care hours as they had been identified as requiring staff support to access the community and take part in activities. Records showed people accessed activities based on their interests. One relative said, "[My relative] leads a very full and active life. Lots of the things they do have been arranged by the staff. They go to gardening group, swimming, bowling. [My relative] likes to do things spontaneously and the staff understand that. They have some things they go to each week, but often it'll be a case of what do you want to do today?"

Staff had online access to a guide for social care staff produced by the local authority. This was a long list of frequently asked questions with signposting to services which staff could access if they needed to. For example, the guide had information and links about how staff should support people to apply for a 'Blue Badge' for their car or how staff should report any broken equipment which had been supplied by the NHS or the local authority. In addition, there was a range of activities which people may be interested in accessing, such as a lacemaking group, a rock choir, and a readers groups. This meant this information was easily accessible to staff so they could be responsive to people's needs.

Good

Is the service well-led?

Our findings

A registered manager was in post, and was present and assisted with our enquiries on both days of our inspection visit. The manager had formally registered with Care Quality Commission in October 2013, and had worked within the care sector for over 20 years. We saw the registered manager had accessed a range of continuing professional development, including completing a diploma in Strategic Management and Leadership in 2016 and was certified to deliver training in positive behaviour management. The registered manager was supported by a range of other staff within the agency office, including locality managers, customer relations managers and team co-ordinators.

People and their relatives were positive in their feedback about the management of the service. When people visited the office to speak with us, we saw they chatted with the registered manager and customer relations managers. It was clear from their conversations that people knew the managers and were comfortable speaking with them. We observed people telling the office staff what they had been up to and their plans for the rest of the day. Relatives told us the communication from the office team was good. One relative said, "The management are good. They seem to have everything under control. If we ever have any queries, then we will give them a ring and talk it through."

The manager told us the culture of the service was to promote independence and to enable people to live full and rich lives. All of the staff we spoke with re-iterated this to us and spoke about the ways they had helped people to achieve their goals and live more independently.

Staff we spoke with told us they felt valued and listened to. One member of staff said, "I've always felt valued and respected in this organisation. I think it comes out in the work we provide. It's why staff stay so long here. The turnover is almost non-existent."

Staff meetings were held regularly within small staff teams who supported the same people who used the service. This meant information was able to be shared about the service in general, and specifically related to individuals care. Staff had been asked their opinions on both staffing issues and the quality of care the service delivered in a staff survey carried out in September 2015.

During our inspection we viewed a range of care and management related records. These were completed to a high standard. All records were complete and stored appropriately. Care records were concise and well managed.

There was a robust system in place to monitor the quality of the service provided. Managers visited each of the properties where care was delivered at least once a month to audit care records to check paperwork has been completed by staff correctly. Audits included ensuring daily care notes had been completed, assessments were up to date, and medicines administration records had been filled in appropriately. We saw actions had been highlighted for staff where audits had identified areas for improvement, such as reiterating to staff that they needed to sign entries made in care records.

The registered manager had undertaken quality monitoring and assurance audits on the service as a whole. We saw she had assessed the service against the five key questions asked by the Care Quality Commission (the Commission), and used the Key Lines of Enquiry, published on the Commission's website to assess whether the service met all regulations. This meant the service was monitoring the quality of the service it provided, and identifying areas for improvement.

The registered manager acknowledged that since the decision had been made that the service would cease to provide services from April 2017, staff morale had dropped. She explained, "Staff are very happy here. We are all proud to work here, and know we do a good job. It's a shame that we cannot continue to provide a service, and it naturally affects staff." She told us the provider would work closely with new providers once they had been allocated, to ensure wherever possible people would be supported by their current staff teams, as staff would be offered employment by the new service provider. However, the manager was aware that some staff were anxious of the uncertainty and had therefore started to look for new jobs. The manager had assessed the impact of the proposed changes and worked closely with the local authority to ensure the service was able to maintain quality, consistency of care and to minimise risks.