

GS Social Care Solutions Ltd

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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

We carried out an announced inspection of GS Social Care Solutions Ltd on 09 and 10 November 2016. The service had last been inspected in July 2013 when we found the service to be compliant with all regulations assessed at that time.

GS Social Care Solutions Ltd is a specialist domiciliary care agency providing support for children, adults and older people within their own homes or out in the community. The service also offers a 2 bedded respite service which caters for ages 0 – 25. 'The Meadows' is predominantly for overnight stays and is aimed at people with learning disability, autism, complex health needs or physical disability. A charity set up by the organisation, the Elysium Community Centre, is also run from the same address and includes a large sport hall, which provides activities that people using the service could access. At the time of the inspection a total of 88 people used the service, however only 32 people were in receipt of regulated activities and therefore included in the inspection.

At the time of the inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

A large proportion of the people supported by the service were children or young adults, many with limited or no verbal communication skills. As a result we were only able to speak to relatives of people who used the service. All the relatives we spoke with told us they were happy with the service being provided and their family member felt safe as a result of the care and support received. We saw the service had suitable safeguarding policies and procedures in place. Staff had all received training in safeguarding vulnerable adults and were able to demonstrate a good understanding of how to report both safeguarding and whistleblowing concerns.

Both staff and relatives of people using the service told us enough staff were employed to meet peoples' needs. Staff told us enough time had been allocated for travelling between calls and many worked solely with the same person, which ensured consistency. Each person using the service had a small team of staff that supported them. We saw that any sickness or other absence had been covered by another member of the team, or if this hadn't been possible, the person and/or their relative had been consulted with before an unfamiliar member of staff used. On occasions we saw that the care-coordinator responsible for a person's care, had completed the shift rather than use someone unfamiliar.

We saw that robust recruitment procedures were in place to ensure staff working for the service met the required standards. This involved all staff having a DBS (Disclosure and Barring Service) check, up to three references and work history documented. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

Staff reported that they received an appropriate level of training to carry out their role. We saw all staff completed a comprehensive induction training programme, followed by a flexible period of time shadowing experienced care staff, before being allowed to work with people who used the service. We saw the service had systems in place to ensure that staff received regular refresher training to ensure their skills and knowledge remained up to date. Staff told us that training was encouraged and they could request to attend any courses or training of interest.

Most of the relatives we spoke with confirmed they had taken responsibility for administering medicines, however positive feedback was given where staff had been involved. Within The Meadows we saw there were systems in place to ensure safe medicines management was maintained. All medicines had been booked in and out, with the relative of the person using the service countersigning all documentation.

Relatives spoke highly of the standard of care received and the caring nature of the staff. They told us that staff treated their relatives kindly, with dignity and respect whilst also promoting their independence wherever possible.

We looked at five care plans, which contained detailed and personalised information about the people who used the service. The care plans also contained individual risk assessments, which helped to ensure people's safety was maintained. We saw that people or their relatives had been involved in planning the care provided and were asked for their feedback through completion of reviews, spot checks and questionnaires.

The service had implemented a number of systems and strategies to ensure care being provided was person centred. We saw that specific interventions and guidelines had been devised to address potential issues a person may encounter when using the service. These had been drawn up with the involvement of the person and/or their relative and in one instance led to bespoke training being devised for all staff members allocated to that person's team.

A weekly schedule of activities was offered, the majority of which were facilitated by the charity, run separately by the service. We saw that sessions were both age specific and also mixed to encourage intergenerational involvement. People were able to choose their own weekly schedule of activities and attend whatever social activities they wanted.

We saw that there were a range of systems and procedures in place to monitor the quality of the service. Quality assurance questionnaires were sent out to people using the service and/or their relatives, along with professionals and staff members on a bi-annual basis. On-going reviews and spot checks were completed to ensure care being provided was effective and met the needs of the people using the service.

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 service had systems and procedures in place to protect people from harm and keep them safe.

Everyone we spoke with told us enough staff were employed to meet people's needs. This was further evidenced through observation of staff rotas.

Safeguarding policies and procedures were in place and staff were aware of the process and how to raise concerns.

The service had appropriate policies and procedures in place to ensure safe medicines management.

Is the service effective?

Good ●

The service was effective

Staff reported receiving enough training to carry out their roles successfully and were provided with regular support and supervision.

The service was working within the legal requirements of the Mental Capacity Act (2005)

People or their relative had consented to their care and decisions had been made in their best interest.

Staff completed regular supervision meetings, which allowed them to receive feedback on their performance as well as bring up any issues they wanted to.

Is the service caring?

Good ●

The service was caring

Relatives we spoke with were positive about the care and support being provided; this was also reflected in the comments on all quality assurance questionnaires.

People and/or their relatives told us that staff were kind and caring and respected their privacy and dignity.

Staff were knowledgeable about the importance of promoting independence and providing choice

Is the service responsive?

Good ●

The service was responsive

Care plans were person-centred and individualised with information about people's life history, likes, dislikes and how they wished to be supported.

The service had a detailed complaints policy and everyone had a copy of this, along with information about how to make a complaint and the necessary forms.

People were asked to provide feedback about the standard of care they received through on-going care reviews.

Is the service well-led?

Good ●

The service was well-led

Quality assurance procedures were in place, to ensure good practice was maintained.

Spot checks and competency checks were carried out by care coordinators to ensure staff worked to high standards and address any issues noted with care provision.

Staff told us they enjoyed working for the service and felt supported in their roles.

GS Social Care Solutions Ltd

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.

The inspection took place on 09 and 10 November 2016 and was announced. We gave the service 48 hours' notice, as the location provides a domiciliary care service and we needed to ensure senior staff members would be in the office to facilitate the inspection, as well as allowing time to arrange for staff to be available to meet with us.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

Prior to the inspection we reviewed all the information we held about the service including statutory notifications and safeguarding referrals and contacted external professionals from the local authority commissioning and safeguarding teams.

As part of the inspection we spoke to the registered manager, deputy manager, senior care co-ordinator, care-coordinator, six staff members and six relatives of people who used the service. Due to most people using the service having limited or no communication skills, it was not possible to speak to them directly.

We looked at five care plans, five staff files, two Medication Administration Record (MAR) charts and also reviewed other records held by the service including audits, meeting notes and safety documentation.

Is the service safe?

Our findings

Due to the majority of people using the service having limited to no verbal communication skills, we were only able to speak with their relatives. We spoke with six relatives and ask if their family member felt safe as a result of the care and treatment provided. All six confirmed that they did, with one telling us, "Yes, they do, they feel very safe." Another said, "Oh yes, I have used them since 2009, never felt the need to change."

During the inspection, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. Both The Meadows and separate kitchen area located within the head office, were clean throughout and we saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The bathrooms and toilets were well kept and surfaces were clean and clutter free. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. We asked the six relatives we spoke to if staff attending their home had worn personal protective equipment when necessary. All confirmed that staff had done so.

We looked at the service's safeguarding systems and procedures. The safeguarding file contained Disclosure and Barring Service (DBS) guidance for adults and children along with a log of all safeguarding concerns and referrals made. The documentation showed that six referrals had been made in 2016, all of which had been assessed and reported correctly following the local authority's safeguarding process. We noted that after an allegation of abuse towards a person using the service had been proven following an investigation by the local authority, the service had reported the staff member responsible to the DBS. This would prevent that person from being able to work with vulnerable people in the future. The service had also incorporated safeguarding questions into staff supervisions in order to complete ongoing tests of their knowledge and understanding.

We spoke with staff about safeguarding vulnerable adults. Each member of staff told us they had received training in this area and displayed a good understanding of how they would report concerns. One told us, "Yes, we did this in house and it covered both children and adults." Another said, "We did the training here, it also covered whistleblowing." A third said, "My responsibility is to report any incidents of neglect or abuse to the right people, which for me would be the care coordinators." Staff told us that the training was refreshed yearly, however this contradicted information on the training matrix, which indicated that safeguarding training was only refreshed every two years.

The service had a whistleblowing policy, which gave clear guidance on how to raise concerns. Staff told us they knew how to raise concerns and would feel comfortable doing so. One member of staff stated, "We have done training in this and I have been through the procedure in the past, the service were very discreet and supportive."

We looked to see if safe recruitment procedures were in place. We saw a member of the recruitment team had completed 'safer recruitment training', following which they had amended the application forms to capture more information about police cautions and criminal history. We viewed five staff files and saw that

each contained a checklist to ensure all required documentation was present; this included a completed application form, transcript of the person's interview, full work history, three references and DBS check. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. All documentation was present in each of the five files viewed. For staff who used their own vehicles, copies of up to date MOT and insurance certification was also kept on file.

The service had an accident and incident file in place which contained a copy of the policy along with a summary of any accidents that had occurred in the last 12 months. The document listed the date of accident, staff and client involved; the service refer to people who use the service as clients, who had followed up on the accident/incident and what the outcome was. We saw there were five completed accident/incident forms within the file, all of which clearly detailed what action had been taken and the related outcome.

We asked staff members about what to do if they witnessed an accident. Each member of staff confirmed they would report this to their line manager and if necessary contact the emergency services. One told us, "I would complete documentation and report to the office. Accidents are logged on paperwork at the client's house as well as centrally." Another said, "Depends on what kind, if needed I would ring an ambulance, if minor, contact the clients parents or family and let them know, before informing the office."

We looked at staffing levels within the service, and how they ensured they met people's needs. Prior to agreeing a package of care, the service completed a risk assessment and discussed the referral with any professionals involved in order to determine a person's support needs. A decision would then be made as to whether current resources could facilitate the referral, if not the service would recruit specifically. We asked staff for their views and opinions of staffing levels. All staff spoken to told us there were enough staff employed and they could safely meet people's needs. One told us, "Always been very good in this regard, definitely enough staff." Another said, "There's enough to meet people's needs. I don't drive, but have more than enough time to get from person to person using public transport." A third added, "We have enough staff, plus we are recruiting all the time." Relatives of people who used the service also told us there were enough staff in place and that they turned up on time. One said to us, "They are very punctual, no problems with staffing levels at all."

Each of the five care plans viewed contained comprehensive risk assessments, which were detailed, easy to read and follow, and person centred. These covered a variety of areas including the environment, medication, physical issues, cognition, relationships and general safety. These were drawn up with involvement from the person and/or their relative and reviewed monthly by a care coordinator. We saw that separate environmental risk assessments had also been completed which covered water temperatures in all bathrooms and toilets, legionella prevention and general health and safety. Safety checklists had been implemented within The Meadows for the hoist, slings and profiling beds, and were completed prior to each use, to ensure they were in good working order.

We looked at the systems in place with regards to medicines management. We saw that most of the people who received domiciliary care or outreach either self-medicated, or were supported by a relative to do so, whereas people who used The Meadows respite service had their medicines administered by a staff member. A consent/authorisation form was in place for all people who were supported with medication, which detailed the responsibilities of the service and those of the person. A risk assessment was also completed which assessed if the person could safely manage their medicines and if not what systems needed to be put in place and what level of support was required.

Relatives we spoke to told us that they were satisfied with the support received from the service. One told us,

"They have some involvement with [relatives] catheter, very good with this, know exactly what they are doing." Another said, "[Relative] has a medical alert card, which the staff carry, I deal with all actual medication."

As well as providing medication training for all staff, assessments were completed to ensure they were competent to administer medication, however we saw that these only took place as part of either the start up review process or during spot checks, which meant that some staff may have been administering medication on their own for up to six weeks before being assessed. We raised this with the registered manager during the inspection, following which they amended the process to ensure any new staff were assessed before administering medication on their own.

The service used their own Medicine Administration Record (MAR) charts. We looked at two of these for people who had stayed in The Meadows and saw that they had been filled out correctly, with all signatures in place. We saw specific guidelines in place for the administration of specific rescue medicines, used when someone was having a prolonged seizure, however we did not see any required medicines (PRN) protocols in place. These provide guidelines for staff regarding what a PRN medicine is for, the required dose and how often it could be administered, time needed between doses, when the medicine was needed, if the person was able to tell staff they needed it and if not what signs to look for. We were told that these were drawn up specifically as and when required.

The Meadows had a locked medication cabinet in situ, which contained an additional lockable compartment for storing controlled drugs, as is required by law. Any medications requiring refrigeration were kept in a separate locked box within the unit's fridge. We saw that all medication had been checked in upon admission, with an accurate tally recorded, before being documented on a MAR sheet. Upon discharge, medication was booked out and the inventory updated to reflect the amount of medication administered. This was signed by staff and the relative of the person using the service. A body map was also completed upon admission to identify any marks, cuts or bruises the person arrived with. This was redone upon discharge and signed by all parties.

Is the service effective?

Our findings

We asked the relatives we spoke to if they thought staff were well trained. All six stated they were, with one telling us, "Yes, definitely. We are happy with the help we get." Another said, "Yes, [relative] has epilepsy, all the staff have had training in this."

Staff told us they had completed an induction upon commencing their employment and were provided with on-going training. One told us, "The induction was quite long, it was over at least three sessions, covered everything I needed to know." Another said, "We went through a presentation, then I had to do all the mandatory sessions, manual handling was a full day, safeguarding at least half a day and first aid was over three days, altogether a long process." A third told us, "We do a lot of training, as well as mandatory sessions, we do stuff on epilepsy, autism and PEG feeds. If you want to do more training, you just need to ask."

The service had a training matrix, which showed what training every member of staff had completed. We saw that all staff had received training in key areas such as safeguarding, moving and handling, first aid and medication. Training records were checked prior to all staff supervision meetings or spot checks, to identify any training needs. As part of the training process, staff had to complete knowledge based assessments, to ensure they had understood the content of each session.

We saw evidence that the Care Certificate was in place at the service. The Care Certificate was officially launched in March 2015 and is the new minimum standards that should be covered as part of induction training of new care workers. Employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

The staff we spoke with told us that supervisions were completed and they found the process useful, however there was some confusion as to how frequently these were held. One told us, "We have supervisions, used to be three monthly, not sure how often they are now but pretty regular. We have input into them, they are very good with the staff here." Another said, "Yes, these are every two months, actually had one yesterday." A third said, "We have these every three months with [training and recruitment officer], but you can call her anytime and meet up, they have an open door policy here." We saw evidence of completed supervision documentation in the five staff files we looked at and each meeting was scheduled to last an hour. The services' supervision policy stated that all staff should receive three meetings per year, however the matrix used to monitor completion showed that staff had completed up to four in the last 12 months.

Most relatives we spoke with took responsibility for nutrition and hydration; however for two people who were supported by staff in this area, feedback was positive. One relative told us, "Yes, no problem with this, they provided what [relative] likes. Another said, "They always make sure [relative] has been fed." A number of people supported by the service were fed via a Percutaneous Endoscopic Gastrostomy (PEG) tube. Guidelines were in place for staff to follow to facilitate this process. A staff member told us, "We have a folder which details what to feed via PEG." Another said, "Most people I support are PEG fed, but this is all arranged

via a nutritionist." Staff told us that information about what people had eaten and drank was recorded in care notes.

People using The Meadows had their meals prepared by staff. Prior to using the respite service, each person was asked to provide information on the types and brands of foods they liked to eat. These items were then purchased in advance and used to make meals for the duration of the person's stay. Food allergy and special dietary information for people using the respite service was in place and included in people's care plans.

By law children aged 16 and over are entitled to consent to their own treatment and can only be overruled in exceptional circumstances, children under the age of 16 can also consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. This is known as being 'Gillick competent'. If they are not deemed competent then someone with parental responsibility can consent for them. All the relatives we spoke with confirmed they had been involved in setting up and consenting to the care and support received. One told us, "They came and visited the house and talked through what we wanted." Another said, "I gave them a briefing of what I wanted, what I wanted [relative] to access and different things like that." However we saw no evidence that any of the children or young adults in receipt of support, had been asked for or given their consent. We also did not see any assessments which evidenced that children and young adults in receipt of care and support were not competent to do so which was why consent had been sought from their relative.

We asked relatives whether staff sought consent. One person told us, "Yes, they always ask." Another said, "Yes, they do, even though it's the same routine each time." A third said, "Yes, they do. We have also provided written consent."

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. We checked whether the service was working within the principles of the MCA. We found the service had an appropriate MCA policy and associated procedures in place and staff had all received training in this area. One staff member told us, "MCA is about capacity and what a person is able to decide for themselves." Another said, "Yes, we have done training in this, it's all about a person's ability to make decisions."

Within the five care files we looked at, we saw evidence of the service's involvement in both best interest and multi-disciplinary team (MDT) meetings for people they supported.

During the inspection we completed a walk round of the premises, which aside from the reception and office areas included The Meadows, several toilets, a large kitchen, a lounge area known as The Butterfly Suite and large sports hall both owned by Elysium Community Centre. We saw that consideration had been given to ensuring the environment was dementia friendly, with toilets containing contrasting toilet seats and handrails to make them easier to identify. Lighting throughout was bright and consistent, minimising the number of shadows and the flooring was plain and neutral in colour. We saw that the home had large easy to read signage to indicate the toilets and bathrooms.

Within The Meadows, we saw that one of the bedrooms had been created as a 'Safespace' room, designed to cater for people with autism, epilepsy, multiple learning difficulties or behaviours which challenge. It provided an extremely robust space and provided a space in which someone could sleep, move, roll or play

freely, reducing the risk of injury by eliminating hard surfaces, whilst the other contained a profiling bed and mobility equipment to meet the needs of people with limited mobility and/or health needs.

Is the service caring?

Our findings

Relatives of people using the service told us that staff were kind and caring. One person said, "Yes, my [relative] is very happy with them, they smile a lot which shows they are happy with the care they are getting." Another told us, "Yes, they are very kind and caring. If [relative] wasn't happy they would let me know."

We asked relatives to give us their impressions of the staff, one said, "They are very friendly and helpful." Another told us, "Some are fantastic, some are not as good but still do a great job." A third added, "They all seem very friendly and very nice, really happy with them."

The service had a dignity champion. A dignity champion is a designated person who is passionate about maintaining people's human rights and person centred care providing support to the team to achieve this. We spoke to this person who told us, "I am a dignity champion; I attend seminars about this and ensure it's incorporated into the service. It's all about respecting people, asking for their permission and making sure they are comfortable with what you are doing." Through the care plans we saw that people had been asked for their preferences regarding the gender of their carer.

We looked at whether staff were treating people they supported with dignity and respect. We asked staff for examples of how they incorporated this into daily practice. One said, "I treat the client as if they were my own [relative], or how I would like to be treated. When doing any personal care I make sure doors are closed and they are covered up." Another told us, "It depends on the needs of the person, I cover up with a towel and don't watch when they are eating or using the toilet, providing it is safe to do so."

Relatives confirmed that staff were mindful of people's dignity and respect, telling us that staff were 'very good in this area' ensuring the explained what they were doing at all times.

The staff we spoke with displayed awareness and understanding of how to promote people's independence and the importance of providing choice. One told us, "With adults, try to let them do whatever they can such as make a cup of tea, wash their own cup. Make sure you don't take over, just offer to help if needed." Another said, "Show them new things, explain things to them, and discuss transport links so they can get around, direct them to ways in which they can do things for themselves." A third said, "I provide options for people, show them different items and look for signs or indications of which they want."

We asked relatives for their views; one said "To be honest it's set what my [relative] does. They attend youth club, bike club, keep in touch with their friends, even though there is a set routine which they support each week, these are all the things my [relative] chooses to do." Another said, "Yes, they provide lots of choice, they discuss these with me."

We saw that the service used a person centred recruitment process, recruiting specifically for individual care packages and asked each person and/or their relative if they wanted to be part of the process and help choose their own support team.

We saw that all people who used the service received their own care file which contained copies of all documentation relating to their care package. We found some information within care plans was produced in easy read format, along with pictorial representations, which made it more accessible to the people who used the service and helped them understand the support and care being provided.

We saw that the service had separate service user guides for domiciliary care and the respite service in The Meadows and these were produced in easy read format.

Is the service responsive?

Our findings

We spoke to relatives of people who used the service and asked if they had been involved in planning their care, all confirmed they had. One person told us, "Yes, I have been involved with all the plans that have been made." A second said, "Yes, they came to the house. They took on board all the things I had to say." We saw in the care plans of two adults using the service, that they had been involved directly in discussing their care; however we saw no evidence that any children or young adults had been involved, with all discussions held with parents or relatives. A staff member told us that on one occasion when meeting with a family to discuss the care package, the person using the service had been asked to go upstairs by their relative, but the staff had encouraged them to stay and participate, however this had not been captured in any documentation.

We looked at whether the service was responsive to people's needs. We saw that each person's care file contained an initial needs assessment, completed as part of the pre-admission assessment process. Needs were formally reviewed on a bi-annual basis, however care coordinators and senior staff reviewed the daily client record sheet and weekly summary sheets, completed by care staff each week and arranged meetings to discuss potential issues or changes to needs before implementing them. We were told that people who used the service or their relatives could also contact the service at any time to discuss making changes to the package of care. We asked the people we spoke with if they felt the service was responsive to their needs, one told us, "Never had to change anything before, we have just asked for an increase in support hours, this is in the process of being sorted." Another said, "Yes, we had to change carers due to re-locating and one of the carers couldn't drive, however they ensured that the core team remained in place."

We asked staff how they ensured the care they provided was person centred. One told us, "This comes from what's in the care plan, from what we have learned and what we know from experience, such as from working with [person's name], although they can't tell me, I know from their reaction they don't like their hair down and are more comfortable in stretchy tops." Another said, "I ask them, if they can't speak I will ask their family, ensure I am doing what they want to do."

Throughout the inspection we saw evidence of person centred practice. The care plans we viewed contained one page profiles and what the service referred to as 'person centred support plans'. The one page profile had been written by the person using the service or their relative and included the sections 'how best to support me', 'things people like/admire about me' and 'what's important to me', This information helped formulate the support plans. The pre-admission assessment captured information relating to the person's background, life history, support required, if any specialist training needs were required before support could commence and what feedback people involved would like from the service along with how often. Individual support plans covered a range of areas including communication ability, medical issues, behaviour management, nutrition and hydration and personal hygiene. Each contained personalised information such as 'I like people to communicate with me by...', or 'what makes me happy is...' with the person's wishes being captured and used to shape the provision of care.

We saw that one person had consented to historical information being shared with the staff in their support team, to help them understand how past experiences had impacted on their thoughts, feelings and

behaviours. The history sheets had been drawn up during sessions with a clinical psychologist. In conjunction with the clinical psychologist, the person's social worker and advocate, the service had then developed a bespoke training programme on how best to support the person, which all staff had to complete before joining the team.

In another care file we saw that postural management instructions in both text and picture format had been devised in conjunction with the person and their family, to ensure that staff knew exactly how the person wished to be supported with their mobility.

For one person who used the respite service in The Meadows, the initial assessment had indicated potential issues with going to bed. In order to address these, the use of a timer had been put in place to support the bed time routine. This had been discussed with the person's relatives and was implemented at home for a two week period prior to using the service, in order for it to become familiar. When the timer went off this indicated it was time to go to bed. We were told that the programme had proven to be successful. Linking in with this we noted that staff working night shift in The Meadows wore pyjamas to help provide a visual cue to people using the service that it was night time, table lamps were also used to ensure the lighting was subdued.

We saw that a range of new documentation and working practices had been implemented within The Meadows. Picture card boards were in situ which explained what activity or task was happening currently and what would be happening next, along with pictures of the staff on duty. For one person who had indicated in feedback that the picture cards were 'childish', a text version had been devised for when they used the facility. We saw that child friendly evaluation forms had been introduced, containing simple wording and imagery to allow children using the service to comment on their experience. A six point scale had been employed to allow people to record what makes them feel happy, uncomfortable, anxious, mad, in pain and lose control; a second scale was completed in which they explained what staff could do to make them feel better.

'My support, my way' documents had been implemented which asked children to provide feedback on what they liked best about being with their carer, what they liked best about themselves, where they would like to complete reviews and what one thing would they like to achieve. However we did not see any of these new forms or documents within the files of children using the domiciliary care or outreach services, which meant they did not have the same opportunity to provide feedback or share their experiences.

We spoke to relatives about whether they were asked for their views on the care and support provided. One said, "Yes, during the first year the carer was on the phone a lot checking everything was okay." Another told us, "We have meetings with them to discuss this." Whilst a third said, "Not yet no, though I have reviewed the care plan with them."

Through speaking with both the registered and deputy managers and looking at care files, we saw that care plans were reviewed monthly by a member of staff and on a bi-annual basis with people or their relatives. Six weeks after commencement of a new care package, the service completed a review, to ensure people using the service and/or their relatives had received all necessary information, were happy with the service being provided, check staff were being effective and had carried out their roles appropriately and ask if any changes or improvements were required. This process was completed for people regardless of whether they received domiciliary care, outreach or respite services.

We saw that an on-going feedback and evaluation form had been devised for use in The Meadows, but had also started to be incorporated into the service as a whole. The form was essentially a rating scale, which

asked people to rate the service in line with CQC's key lines of enquiry (KLOE's) which are; is the service safe, effective, caring, responsive and well-led, as well as provide written comments and feedback. We noted that the style of the form meant it was only suitable for certain people who used the service or relatives as it was not child friendly or written in an easy read style.

Spot checks of each person who used the service were carried out annually. These provided another opportunity to review the package of care as well as allow for competency checks of staff members to be completed.

People using the service were able to link in with activities run by Elysium Community Centre, the charity run from the same address. As a result the service was able to offer access to activities seven days per week. A schedule of available activities was provided which included a film club, art and craft sessions and Skills and Sensory Sessions (SASS) a group designed for children and adults with additional needs, where people could play different types of games, do messy play and have use of a bouncy castle. We saw the service also had links with 'Phab' a voluntary organisation that ran a junior health club for people aged 0 – 15, which people using the service were supported to attend. A closed social media page had been set up by the service which staff members used to share ideas and suggestions for outings and ideas, they also provided feedback about places they had visited which may appeal to people who used the service.

The service had a detailed complaints policy in place, which was also available in easy read format, containing the use of images such as a frowning face or thumb pointing downwards to help people understand the content. Each person who used the service was provided with information on how to complain within their personal care file. The service had a complaints file in place which contained copies of the policies along with CQC's guidance on receiving and acting on complaints. A flow cart was also in place which explained the process for handling complaints. Each complaint received had been logged and we saw that during 2016 the service had received four complaints. These all related to individual staff issues and had been fully investigated with action points and outcomes documented.

Relatives of people using the service told us that they were aware of how to complain but had never had cause to. One told us, "Not really had to make any but we have a folder with everything in, including complaints information." Another said, "I've not had to, but all the names and contact details are in the care file if I ever needed them." However, despite having an easy read complaints policy, we did not observe any adaptations to the complaints procedure or systems put in place to make it easier or possible for children to raise concerns or complaints. Within The Meadows a 'red card' system had been introduced which people could hand to staff to indicate they were upset, but this was not used throughout the service, nor did this system provide other visual aids for people with limited or no communication skills to use to identify what was wrong.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The service also employed a deputy manager, a senior care co-ordinator and five care co-ordinators, who were responsible for the day to day operation of the service, overseeing care plans and completing reviews with people who used the service. Due to the setup of the service, relatives we spoke with tended to name one of the co-ordinators when asked if they knew who the manager was. One person said, "No, I don't, I deal directly with [co-ordinator]." A second told us, "Not really, I know some of the names, but tend to deal with the co-ordinator." However a third person said, "Oh yes, I know [registered manager], though I have not met her yet."

We asked staff whether they enjoyed working for the company and if they felt supported by the management team. One told us, "Yes, I love it. The only people who ever gave me a chance to do this type of work." A second said, "Yes, it's a good company to work for, make you feel part of a family." Whilst a third added, "Yes, they were very supportive when I had some family issues." A fourth told us, "Support is good; you can ring and ask or just call in whenever you need to."

We also asked staff for their opinions on the culture of the service. They told us the service was friendly, supportive and that people were approachable. One told us, "It's really nice; everyone is really approachable and will do anything to help." Another said, "It's great, very friendly." We saw that the service validated staff through an 'employee award' programme. This was presented quarterly to the staff member that had received the most nominations, with the winner receiving gift vouchers from a place of their choosing.

We looked at whether the service held regular staff meetings. Feedback from staff was mixed. One staff member told us, "No, we have more individual meetings. The co-ordinator will come out to see us and ask if we are okay. We tend to get emails to update us about things." Another said, "Yes we do, now and again. If there are any changes to care plans, we get emails or phone call from the office to tell us." However a third said, "They arrange one every six months or so. Staff can request a meeting sooner if there is an issue with a client's programme."

The service had a staff meeting file. We noted that monthly team meetings were held for office based staff such as the managers and care-coordinators, which looked at productivity and provided an opportunity to pass on information about care packages, referrals and other business related information. Team meetings had also been facilitated for staff who worked in The Meadows, with two meetings being held since this opened fully in October 2016. We also saw evidence that meetings had been held with domiciliary care and outreach staff to discuss the programmes of people who used the service, which were facilitated by the care co-ordinators. However all examples we saw were for meetings ran by just two of the five care coordinators, involving staff teams for five people who used the service.

Quality assurance questionnaires were sent out to people who used the service or their relatives, any professional involved with the service and staff members on a six monthly basis. Each questionnaire had been specifically designed for its target audience. People using the service or their relatives had been asked to rate the service in a number of areas including involvement in care, communication, effectiveness of the service, if they felt safe, if the service was caring, responsive to their needs and well-led. Whereas staff had been asked to list what they liked about working for the service, any improvements they would like to see and if they thought the service they provided was in line with CQC's key lines of enquiry. The last set of questionnaires had been distributed in July; however response rates had been low. Of the 80 sent out to people and their relatives, only 19 had been returned, just 8 out of 47 staff had filled out their questionnaires and only 2 returns had been received by professionals from a potential total of 55. We saw that data from the questionnaires was available on the services website, along with responses to recommendations made. In one instance everyone using the service had been re-sent copies of the complaints procedure, as 36% had indicated they were unsure of what to do. Comments received on the completed questionnaires included, 'very prompt, very professional and very caring' and 'provided someone who fully understands the needs of our [relative]. We can have a complete break knowing they are safe and happy.'

The questionnaires formed part of the quality assurance (QA) procedures in place at the service. The QA file showed that a six week start up review was carried out with everyone who began using the service, followed by a three month follow up review via telephone. A further review was completed at six months along with annual evaluations and spot checks, to ensure people were happy with the care being provided. However aside from the QA information collected from reviews, questionnaires and spot checks, and seeing that care files were reviewed on a monthly basis by the co-ordinators, we did not see evidence of any other internal audits being completed to monitor the quality and effectiveness of the service.

The service had a range of policies and procedures in place, which were accessed via the computer system. This included key policies on medicines, safeguarding, MCA, complaints and moving and handling. Policies were regularly reviewed and updated. We saw evidence that staff had been provided with log in details in order to access policies electronically.

The service had made numerous links with the local community and other professional bodies, with community groups using the sports hall and other facilities such as the Butterfly Lounge and sensory room. We saw that the service had signed up with a number of organisations including, Driving Up Quality, Think Local Act Personal (TLAP), the Health Charter and Social Care Commitment.