Sefton New Directions Limited

Sefton New Directions Limited - Home Service

Inspection report

3rd Floor, The Investment Centre
375 Stanley Road
Bootle
Merseyside
L20 3EF

Tel: 01519343987
Website: www.ndirections.co.uk

Date of inspection visit:
28 April 2016
29 April 2016
06 May 2016

Date of publication:
28 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Sefton New Directions provides three distinct services. A short term re-enablement service for people in their own homes, 'shared lives', a long-term domiciliary care service for people with learning difficulties and a supported living service for up to 15 people with learning difficulties in five tenancy locations.

This was an announced inspection which took place over three days on 28, 29 April and 6 May 2016. The inspection was carried out by an adult social care inspector.
The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We saw that some of the medication administration records were not always clear in the supported living service so it was not clear whether people had received their medicines. There was a need to develop audits for checking medication standards to help ensure consistent safe standards were developed and maintained.
We told the provider to take action.

We were able to speak with people at the two supported living locations we visited. They looked relaxed and had an obvious positive rapport with the staff members providing support. Those able to express an opinion said they felt safe with the support they received.

We saw that people requiring support when out in the community to ensure they were safe, had fully developed plans in place. Staff were arranged to support this depending on each person's needs. People's support plans evidenced this.

We found staffing of the service was under regular review and there were sufficient staff available to support each of the three designated services within the Home Service.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files and found that appropriate applications, references and security [police] checks had been carried out. These checks had been made so that staff employed were 'fit' to work with people who might be vulnerable.

The staff we spoke with clearly described how they recognised abuse and the action they took to ensure actual or potential harm was reported. All of the staff we spoke with were clear about the need to report through any concerns they had. There had been a number of safeguarding referrals and investigations since our last inspection of the service. Agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This rigour helped ensure people were kept safe and their rights upheld.

Arrangements were in place for checking the care environment to ensure it was safe. There were protocols in place so that staff in all three services monitored the living environments and reported through any issues.

We observed staff provide support and the interactions we saw showed how staff communicated and supported people as individuals. Relatives told us that staff seemed well trained and competent. Communication between relatives, people being supported, staff and senior management was effective.

Staff were supported by on-going training, supervision, appraisal and staff meetings. Formal qualifications in care were offered to staff as part of their development. We saw there were plans to further develop training particularly with respect to the share lives service.

Local health care professionals, such as the person's GP, and Community Mental Health Team were regularly involved with people. The feedback we received from people using the services, professionals and relatives evidenced good liaison and appropriate working to ensure people received good health care support.
Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

We discussed with staff and the people living in supported living how meals were organised. We saw that these were organised individually and people were encouraged to choose and plan their own meals.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

We saw that staff respected people's right to privacy and to be treated with dignity. For example staff were aware of how one person's behaviour might impinge on the right of others sharing the accommodation and had made arrangements to minimise this.

All family members and people spoken with felt confident to express concerns and complaints. Most people told us that issues were dealt with at reviews and the service was generally very responsive to any concerns raised.

All of the managers we spoke with were able to talk positively about the importance of a 'person centred approach' to care. Meaning care was centred on the needs of each individual rather than the person having to fit into a set model within the service. People using the service and relatives told us they felt the culture of the organisation was fair and open.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes both internally and external to the service. There was a clear management hierarchy and we saw that new ideas and service improvements were effectively developed and communicated.

Internally there were other key audits carried out to monitor standards.

You can see what action we told the provider to take at the back of the full version of this report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We saw that some of the medication administration records were not always clear in the supported living service so it was not clear whether people had received their medicines. There was a need to develop audits for checking medication standards to help ensure consistent safe standards were developed and maintained.

There was a good level of understanding regarding how safe care was managed. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure they were safe.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff employed to help ensure people were cared for flexibly and in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

The service worked in accordance with the Mental Capacity Act 2005. People told us they were able to make their own choices and were involved in decisions about their support.

Systems were in place to provide staff support. This included on-going training, staff supervision, appraisals and staff meetings.

People's care documents showed details about people's medical conditions and also appointments with health care professionals such as GPs and district nurse teams to help support people in their own home, supported living or shared lives.

Staff said they were supported through induction, supervision, appraisal and the service's training programme.

Is the service caring?

Good

The service was caring.

The feedback we received from all three areas of the service evidenced a caring service. People being supported and their relatives commented positively on how the staff approached care.

We observed positive interactions between people being supported in supported living and shared lives. Carers treated people with respect and dignity. They had a good understanding of people's needs and preferences.

People we spoke with and relatives told us the manager's and staff communicated with them effectively about changes to care and involved them in any plans and decisions.

Is the service responsive?

Good

The service was responsive.

People's care was planned so it was personalised and reflected their current and on-going care needs.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Good

The service was well led.

The registered manager provided an effective lead in the service and was supported by a clear management structure.

We found an open and person-centred culture. This was evidenced throughout for all of the interviews conducted through to observations of care and records reviewed.

There were systems in place to gather feedback from people so that the service was developed with respect to their needs.

Sefton New Directions Limited - Home Service

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 checked 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 was an announced inspection which took place over three days. The inspection was carried out by an adult social care inspector.

Prior to the inspection we accessed and reviewed the Provider Information Return (PIR) as we had requested this of the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

On the first two days of the inspection we visited two of the supported living [tenanted] locations where people lived who were supported by the service. During the visits we were able to see and interact with the people who lived there. We also attended a meeting where we were able to talk to staff and people who were supported by the Shared Lives Scheme. On 6 May we visited the central offices for the Home Service. Over the period of the inspection we contacted people and professionals who were able to provide us with feedback regarding the re-enablement service which supports people in their own home for a period of time when they first come out of hospital.

Across all of the services we spoke with twelve staff including care/support staff, three senior managers for the services and the Registered Manager. We also met with the Nominated Individual for the provider. We looked at the care records for 10 of the people being supported across the Home Service including three medication records, two staff recruitment files and other records relevant to the quality monitoring of the service such as safety audits and quality audits. We also received feedback from three family members of

people being supported as well as two professionals who have had input into the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed medication management in the supported living houses we visited. We spoke with care staff and the service manager and reviewed all three medication administration records [MARs] for the people living there. Medication was stored in a separate secured cabinet for each person. We were told that all medicines were administered by designated staff members who had received the required training. Following each individual administration the records were completed by the staff. This helped reduce the risk of errors occurring. Medicine administration records we saw were completed for that day to show that people had received their medication.

We were told the competency of staff to administer medicines was formally assessed to help make sure they had the necessary skills and understanding to safely administer medicines. We spoke with staff who told us that competency checks were made by the service manager following initial training. This was also confirmed by the service manager and when we looked at staff records we could see examples of these assessments.

We found some anomalies with the medication administration records [MARs] which meant that they were not always clear. For example the written codes used to record medicines on two of the MAR's were not referenced anywhere on the chart. We asked staff what this meant and they were unclear as to whether the persons concerned had refused their medicines or whether the entry referred to the persons attending the day centre. It was unclear, from the chart, therefore whether the person had had their medicines. In another example we saw one person's MAR recorded a cream to be administered twice daily. There was no record of this being administered. The cream was available in the person's medication cabinet. We asked two staff whether the person was receiving the cream but they were not aware of this medicine. Another staff had some knowledge and said it had been used awhile back but not now. There was no record of the cream in the person's care file. The lack of staff knowledge regarding this medication and lack of review of the medication record was a concern.

We discussed this with the manager for the service. We were told that the medicines were 'checked' regularly. These were not documented however and there was no audit tool in use to help with this process. The service manager said they would look at formalising a medication audit tool which would improve the monitoring of medicines at the service.

These findings were a breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We were able to speak with people at the two supported living locations we visited. People were settled and some were keen to tell us about their day and how they were supported. All of the people we saw and spoke with appeared comfortable with the support they were receiving from the care staff and had an obvious warm rapport.

One person showed told us about their plans for the day and how they spent the rest of their week. They

looked relaxed and had an obvious positive relationship with the staff member providing support. Those able to express an opinion said they felt safe with the support they received.

We reviewed the care of one person whose behaviour provided challenges for the staff and people living at the house in terms of safe management. Staff told us about the complexities of managing the daily routine so that any risks regarding safety were minimised. We saw this was being managed creatively and helped ensure the safety of the individual concerned as well as fellow residents in the house.

People requiring staff support when out in the community to ensure they were safe and appropriately supported, had fully developed plans in place. Staff support was assessed and provided in consultation with each person and developed to take in to account their individual care needs. We saw this was detailed in people's support plans we viewed. People were out with staff support on the days of our inspection visit.

All of the people in the supported living accommodation [that could express a view] and family members contacted felt that support was being provided in a safe, secure environment. We were also told that family and friends visited on a frequent basis and all knew who to speak with if they had any concerns. One relative commented, ''The staff are exemplary. [Relative] can be difficult but staff understand and know her well.''

We spoke with shared lives carers as well as people receiving support from the re-enablement service. The feedback we got was very positive and people told us they felt safe and the service provided was very consistent. Carers in the share lives scheme told us they felt supported by frequent contact and reviews by the shared lives officers so they knew they always had a contact for any issues that might arise.

We asked about staffing for the various services. Staff input was agreed depending on assessment and funding by social services. Most of the people we spoke with in the supported living accommodation needed 'one to one' support whilst out in the community for developing social skills outside of the supported living environment. We saw from the duty rotas that the houses were covered adequately. We saw staff escorting people out for the day as part of their routine. Four houses each had a sleep in staff and one house had a waking night staff. Extra cover was generally by staff who knew the people being supported. There was always a senior manager on call for any emergencies or issues arising.

We spoke with people receiving care from the re-enablement service who told us that staff always turned up on time and were very reliable. This was seen as the most reassuring element in terms of feeling secure with the care provided. One relative told us, ''We felt confident in knowing that [relative] was receiving the best care and this was very reassuring.''

The Provider Information Return (PIR) told us that staffing was always being assessed and monitored to ensure each of the services run smoothly. The Provider Information Return [PIR] told us a focus for the forthcoming year was a 'review of staffing levels for the shared lives team to ensure sufficient levels of shared lives officers to recruit and facilitate carer learning alongside day to day tasks of the post'.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at three staff files of staff more recently recruited and found that appropriate applications, references and security [police] checks had been carried out. These checks had been made so that staff employed were 'fit' to work with people who might be vulnerable. Shared lives officers were responsible for ensuring checks were carried out for any prospective shared lives carer. We spoke with three shared lives carers who told us they had undergone thorough checks including interviews with shared lives officers and were subject to continued monitoring and support.

All of the staff we spoke with in all three services clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training within the companies recommended guidelines. All of the staff we spoke with were clear about the need to report through any concerns they had. Staff told us; "Any safeguarding incident is reported through very promptly (supported living)'' and "One of the first things you do on induction is safeguarding training (shared lives).''

There had been a number of safeguarding referrals and investigations since our last inspection of the service. We discussed some of these incidents and how they had been managed. We saw some of the incidents had been identified internally and referred appropriately to the safeguarding authority [social services]. Agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This rigour helped ensure people were kept safe and their rights upheld. We saw that local contact numbers for safeguarding were available.

Arrangements were in place for checking the care environments to ensure they were safe. Both supported living environments were owned by individual landlords and we saw there were protocols in place so that staff monitored the environment and reported through any issues. For example at the supported living services we visited, the house manager carried out documented checks of the environment. These were supported by visits on a monthly basis by the service manager. The service manager told us what they did on these visits but there was no written record of the visits and checks made. We discussed the need to evidence this and record observations as well as any actions needed and feedback to staff.

Amongst the records seen we observed each person had a personal evacuation plan [PEEP] in case of an emergency such as a fire incident.

We looked at some records of people receiving support from the re-enablement service and saw that there were detailed assessments of the care environment when people where initially assesses by the service. These included risk assessment looking at health and safety of the environment as well as any equipment in use.

Accidents and incidents were recorded and monitored by the service. We saw how these were collated and analysed by the quality assurance manager for the service. A report was compiled which was also reviewed by the health and safety committee consisting of senior managers.

Good

Is the service effective?

Our findings

Sefton New Directions - Home Service provided support for people in three designated services. Two of these – the supported living and shared lives scheme – supported people who have learning disabilities and/or autism and associated mental health care needs which can affect their quality of life. When we spoke with staff the main aim of the support was to encourage people to be as independent as possible and enjoy as full a daily life as possible based on people's individual chosen lifestyles.

The provider information return [PIR] completed by the registered manager prior to our inspection reinforced this approach and told us the importance of developing staff throughout the services so they had the confidence and knowledge to support people effectively. For example, the PIR said a key objective for the service was to develop pre and post approval training for shared lives carers. This was an issue we identified from our interviews with shared lives staff officers and existing carers. One carer said, the agency is really good but there is currently a lack of pre-approval training.'' The registered manager told this had clearly been identified and would be instigated in the near future.

We observed staff provide support, particularly in the supported living houses we visited. The interactions we saw showed how staff communicated and supported people as individuals. Staff were able to explain in detail each person's care needs and how they communicated these needs. We saw care records included reference to peoples preferred method of communication.

One person spoke with us and told us about a project they were involved in and how staff supported them to carry this out. We observed the person had good rapport with staff who supported them on a 'one to one' basis. This person was encouraged to be independent, for example using public transport with support. The person's relative said at the last review of care, ''We are very happy for [person] to share the house with friends. Staff are very good and I always enjoy visiting.''

Relatives we spoke with told us that staff seemed well trained and competent. We were told support staff appeared to have a range of life skills and were seen to be doing a very good job. Communication between relatives, people being supported, staff and senior management was seen as efficient and effective across all three services. All of the relatives spoken with felt they were kept up to date with any changes or developments. They felt staff had the skills and approach needed to ensure people were receiving the right care. We spoke with a shared lives carer who had been with the service for a number of years. They told us that communication and support by staff [shared lives officers] had increased recently and ''Communication and support is first rate.''

We looked at the training and support in place for staff across all three services. We had generally positive feedback from staff and shared lives carers. Some of the shared lives interviews identified the shortfall in the pre-approval training for carers and staff identified there could be more training in the supported living service around specific subjects such the Mental Capacity Act 2005. The PIR submitted by the registered manager had identified these issues and they were prioritised for development. We saw that staff files contained training plans and certificates of attendance at training. We saw that some [new] staff had

commenced the new Care Certificate which standardise induction training for staff with nationally agreed induction standards. We were told by the registered manager that this is 'up and running' in the re-enablement service and will be extended throughout the rest of the Home Service including shared lives carers. Staff interviews were positive in that the service supported their training and the records we saw evidenced staff were updated in 'statutory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness.

In addition some staff had undertaken training with respect to the care needs of the people being supported. For example we spoke with a care staff from supported living who had attended training around epilepsy as this was background knowledge needed to support people in that particular accommodation. The staff member was able to describe the care of the person in relation to observation and any extra support needed. Another staff told us about a course they had attended around challenging behaviour and how this had helped with their approach in certain situations with people being supported.

House managers we spoke with told us that most staff had a qualification in care such as NVQ [National Vocational Qualification] or Diploma and this was confirmed by records we saw. Staff spoken with said they felt supported and the training provided was of a good standard. They told us that they had had appraisals by the manager and there were support systems in place such as supervision sessions and staff meetings. A shared lives carer told us ''We are supported really well. Managers are out immediately if we need any support.''

We saw, from the care records across all services, that local health care professionals, such as the person's GP, and Community Mental Health Team were regularly involved with people. One person we saw (supported living) was under regular review by the Community Mental Health Team. Another person (re-enablement) told us, "We are waiting to be assessed by the continence service – the agency staff have been really good at chasing this up.'' A relative we spoke with [supported living] said, ''The staff have arranged for the optician to review [person] in the home and have been really good at arranging this.''

We spoke with a person being supported in the share lives scheme who told us about their medical condition and how it was now much better monitored [since the placement] through regular health appointments. They said, "I go to all the appointments and make sure I take my tablets.''

We spoke with a social care professional regarding the re-enablement service who told us, ''It's a brilliant service – they are spot on with their assessments and continued care. They have dealt with some difficult issues and they liaise well [with us].''

Relatives gave positive feedback about health care support. They described a proactive service [both re-enablement and supported living] which identified any issues regarding people's health and ensured they received the right support and intervention. They told us people had access to health care professionals when they needed them; for example district nurses, occupational therapists or a GP. Care files we reviewed in both of these services further evidenced this.

We looked to see if the home was working within the legal framework of the Mental Capacity Act 2005 [MCA]. 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.

Staff told us that time needed to be taken to help ensure people were supported to make decisions. For example, in supported living we saw a support plan which told us the person had difficulty making certain decisions regarding finances, medication and aspects of health care. The plan talked positively about supporting the person to try and make these decisions. We also saw reference to decisions being made in people's best interests involving family, support workers and advocacy if necessary. A good example we saw of this was a best interest decision regarding a person who had to have blood tests undertaken to monitor a medical condition. This had involved the person's relatives and health care professionals. We saw that in this example the person's mental capacity had been assessed with respect to this decision.
These assessments helped identify people who may need referring legally to the Court of Protection [COP]. The COP provides a legal framework for making decisions for people living in the community who lack capacity. A staff member told us, "Myself and senior staff have all completed training around mental capacity."

We discussed with staff and the people living in supported living how meals were organised. We saw that these were organised individually and people were encouraged to choose and plan their own meals. We saw they were in the kitchen and helped prepare a meal with staff support. Each of the care plans we saw [supported living] contained a health action plan and this also contained any plans to support people who needed dietary input. We saw that people in supported living do much of their own shopping for food with support from staff.

Good

Is the service caring?

Our findings

We received positive feedback from all areas of the service regarding the caring nature of the staff. Comments we received included: ''Everything is fine, I feel well cared for (shared lives)'', ''Since moving in my life has changed in a good way (shared lives), ''Staff are extremely good'' (supported living), ''Staff are amazing – they treat (person) like their own'' (supported living), ''Staff are very nice'' (re-enablement), and ''They are very caring and like a breath of fresh air'' (re-enablement).

We observed the interactions between staff and people living in supported living accommodation. We saw there was an obvious rapport and understanding. People varied in their level of care need and communication. This meant people needed support interventions aimed at planning their day and future activity on an individual basis.

Communication was seen as a priority to carrying out care. Care files referenced individual ways that people communicated and made their needs known. We also saw examples were people had been included in the care planning, so they could see and play an active role in their progress. For example we saw a recent care review involving the person and their family. This was signed by the person concerned and recorded there comments.

Most people in supported living had designated 'one to one' staff who supported them on a daily basis. We saw staff respond in a timely and flexible way depending on how each person communicated. We saw there was positive and on-going interaction between people and staff. We heard staff taking time to explain things clearly to people in a way they understood. When we spoke with staff they were able to tell us why people needed different approaches at certain times and how this had been agreed and was consistent.

We attended a meeting at a day centre to meet shared lives carers and people they were supporting. The meetings were new and were aimed at providing an opportunity for people to mix and share experiences. It also provided an opportunity for people to feedback any issues. Staff had actively promoted a survey form to collect any feedback. One shared lives carer told us this was a good idea and they felt more involved and supported.

The staff we spoke with had a good knowledge of people's needs and were able to explain in detail each person's preferences and daily routine, likes and dislikes. These were also recorded in care files we reviewed. This theme was supported by the observations, interviews and records we saw on the inspection in all three areas of the service.

We saw that staff respected people's privacy. In one example a person in a supported living house could present with behaviour that threatened other people's sense of wellbeing and dignity. Staff were very aware of this and managed to ensure care was organised to support each individual and promote their wellbeing as much as possible.

We asked about advocacy service available for people. We saw that local advocacy service was being used

for one person in supported living to help represent their views. A 'best interest' meeting for another person had included discussion around the use of an Independent Mental Capacity Advocate (IMCA).

Good

Is the service responsive?

Our findings

When we spoke with people on the inspection (supported living and shared lives) and made observations we found the care to be organised to meet people's needs as individuals. For example we reviewed some of the daily activities and routines people were engaged in. These were varied and had been chosen by the people concerned. One person told us about attendance at a day centre where they were able to join in with crafts such as woodwork. The person also talked about decorating their room and planning a holiday. All of the people we saw had full programmes of daily activity which they were involved with planning and which reflected their interests.

Care records contained individual life histories and events as well as recording the way any personal care should be delivered. We found that care plans and records were individualised to people's preferences and reflected their identified needs. Some of these contained very good detail and there was evidence that plans had been discussed with people and also their relatives if needed. We could see from the care records that staff reviewed each person's care. Some of the care records in the supported living houses were reviewed more infrequently and we spoke with the manager about standardising this so peoples care plan reviews were more consistently undertaken. There were daily written reports to back up the care planning.

The re-enablement service was more geared to short term goals in terms of rehabilitation following hospital admission. The care records we looked at clearly identified the key areas of care and how these would be supported. It was also clear how elements of this were supported by input from health professionals. We saw the personal care element of the care plan was well defined so it was clear for staff how this was to be carried out. We received feedback which evidenced a personalised approached to care. One relative commented on a survey form: "'' The care and support given to [person] was excellent. We felt very confident knowing [person] was getting the best care. Nothing was too much trouble and [person] has come on leaps and bounds.''

People we spoke with told us they had meetings [reviews] and were involved in planning their care. We saw these meetings recorded in the care files we reviewed for people in supported living. Staff explained that it was not possible sometimes to actually sit and do a formal review of the care plan due to people's lack of focus and concentration; however, key aspects could be reviewed with the person as necessary and recorded. This showed an understanding of the flexibility needed in the approach to care. In the re-enablement service the care was formally reviewed after three weeks with input from a social worker. The shared lives officers reviewed care on a three monthly basis with each carer and the person they were supporting. The person being supported was interviewed separately so they could contribute freely to the review and highlight any issues.

In the PIR form the provider gave us was an example of a person who had benefited from the 'matching and introduction' process undertaken with shared lives to ensure the person was supported by a carer who was best suited: 'Using the matching and introduction process allowed D and new carers' time to see if the arrangement was right for them.' This had helped the person to progress after previous placement breakdowns and showed evidence of a more personalised approach to care provided.

We asked people and their relatives if they were listened to if they had any issues or concerns. One relative said, "We are given a folder with the complaints process in. We are free to raise any issues however and staff are very open.'' All family members and people spoken with felt confident to express concerns and complaints. Most people told us that issues were dealt with at reviews and the service was generally very responsive to any concerns raised.

We saw there was a complaints procedure. We reviewed in some detail the process and outcome for one complaint received and saw the service had spent a lot of time working to reach a conclusion [although there were still some issues to address] and had worked also with social services to help achieve this.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager was supported by senior care managers for each of the separate services provided by the Home Service. We also met with the nominated individual for the provider during the inspection.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes both internally and external to the service.

The registered manager was fairly new to the post and talked about creating an 'open' culture for the service. This was expanded on in the PIR completed by the registered manager; 'We have developed towards a more open culture where the team feel safe to question opinion and practice'. The aim of this was to create a 'strong culture of support and caring for each other' and staff would feel supported to 'question opinion and practice'. The registered manager has introduced a number of forums aimed at achieving this including forums for both staff and people using the service. We experienced one such forum when we visited the shared lives meeting on one day of the inspection.

When first in post the registered manager had commissioned a staff survey to help gauge the culture of the service and also the key issues. We were shown the outcome of this and it was clear that the process had helped establish some clear objectives for the service.

This approach was recognised by staff we spoke with. All commented on the freshness in approach and said they felt listened to and felt good progress was being made in areas such as training and staff meetings. For example the shared lives officers spoke about the team meetings every six weeks with the registered manager. One staff commented, ''There's been a change in the culture. The [registered] manager is approachable and very supportive of the team.''

All of the managers we spoke with were able to talk positively about the importance of a 'person centred approach' to care; meaning care was centred on the needs of each individual rather than the person having to fit into a set model within the service. This was seen as key to developing any support for people. The shared lives offices talked about providing more opportunity for people to 'get together socially' to provide mutual support. This was seen as something new and evidence of a development of a more inclusive and open service.

Similarly people using the service gave evidence to substantiate how the positive changes had affected them. A share lives carer commented, "There is more opportunity to feedback issues and get support. The scheme is supporting us very well. [Registered manager] has changed the ethos. She shares much more information.''

The registered manager said there was further progress needed and was keen to provide more forums for people to get involved. For example there remained a need to send out formal surveys to people using the

service and their relatives to further compliment the forums already in place.

Externally the service was keen to seek out and get involved in areas of 'best practice'. For example the service has made links with a local college regarding further training around challenging behaviour. This is related to a need involving specific persons being supported. The shared lives scheme has contact with Shared Lives Plus which is a national forum for the formation of best practise standards for shared lived.

Internally there were other key audits carried out to monitor standards in supported living houses [for example]. This included house manager's audits covering health and safety and checking people's personal allowances. These audits were complemented by senior management audits carried out annually or bi-annually. We discussed the observation we had made regarding the lack of formal auditing by the supported living manager when visiting the supported living houses. This included, for example, a lack of a medicine audit, care planning audit or health and safety audit. We had discussed this with the service manager who told us they would look at developing these.

The service had sent us notification of incidents and events which were notifiable under current legislation. This helped us to be updated and monitored key elements of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We saw that some of the medication administration records were not always clear in the supported living service so it was not clear whether people had received their medicines. There was a need to develop audits for checking medication standards to help ensure consistent safe standards were developed and maintained.