Creative Support Limited

# Creative Support - Sue Starkey House & Shipton House

## Inspection report

Sue Starkey House
6 West Arbour Street
London
E1 0FB

Tel: 07817460325
Website: www.creativesupport.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place between 18 and 20 October and was unannounced on the first day. This was the first inspection since the provider took over responsibility for this service in November 2015.

Sue Starkey House provides extra care and supported living services to people with a range of needs, including older people, people with mental health needs, learning disabilities and physical disabilities. At the time of our inspection 29 people were receiving support with personal care at this location. Sue Starkey House consists of 32 self-contained single flats and eight double flats over a five storey building. There is a large communal living and dining room, a shared kitchen and a computer room on the ground floor and a second floor library and darts room.

The service's registration includes Shipton House, which is a smaller extra care service for older people, particularly people living with dementia. The building had been recently renovated, and consisted of 13 self-contained single flats with a living room, accessible kitchen and wet room. There was a small shared lounge and kitchen on the ground floor. The building adjoined a day centre, which was attended by several people who lived in the building.

The service had a registered manager, who was also area manager for the provider. 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.

The provider had measures in place to safeguard people who use the service and mitigate risks. Risk assessments were reviewed regularly and contained detailed risk management plans, including moving and handling guidelines and guidelines for addressing when people became upset or displayed aggressive behaviours. There were checks in place to keep premises safe, although the provider had found that some equipment was overdue for servicing and was taking measures to address this. There were processes for checking people's safety and the safety of the building. When the service supported people to manage their money, the provider obtained detailed information on people's support needs in this area, however there were not sufficient checks of people's finance records to ensure that people were safeguarded from financial abuse or loss. There were systems of audit to ensure that people's medicines were safely administered by staff who had had training and observations of their competency in this area.

Care plans contained detailed information about how best to support people, and people had appropriately consented to their plans. The provider carried out assessments of whether people were able to consent to their care plans and whether they may be at risk of being deprived of their liberty. We found some care plans had not been updated when people required less support, although the provider was working with the local authority to update these. Reviews of care plans were taking place regularly and in response to particular events. The provider compiled plans to meet the need of people living with dementia and provided life story

work and reminiscence activities to stimulate people's memories. Keyworking systems were being implemented for people, although these were not yet fully embedded in the service and although the service recognised and celebrated people's achievements, goals were not always set in a way that was specific and measureable.

People were supported to maintain good health and nutrition through planning and monitoring, and where there were concerns about people's health or when people were refusing support, the provider worked well with other agencies in order to address these issues.

Staff received good levels of training and supervision, including in key areas such as dignity and safeguarding. Staff were recruited in line with safer recruitment processes, but staff were sometimes stretched at evenings and weekends, and some people did not receive their agreed support hours in line with their plans. Where complaints were received, the provider had investigated and addressed these, and worked to ensure that people knew how to complain.

There was a varied activity plan which was implemented with input from people who used the service and external agencies including charities and volunteers. Volunteers had worked with people who used the service to design and build a dementia friendly garden at Shipton House. People were supported to speak up through tenants meetings and events forums, and individual activities sessions were carried out to ensure that activities met people's needs.

We have made a recommendation about how the service carries out checks of equipment, pull cords and finances.

## 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.

There was a thorough process for ensuring the safety of the building, including fire safety. However some checks were not adequate to protect people from financial abuse and ensure emergency pull cords were safe. Some equipment was overdue for maintenance, which the provider was in the process of addressing with the local authority

Safer recruitment processes were in place, but some visits from staff were shorter than planned and people told us that staffing levels were low at weekends and evenings.

There were processes in place to ensure that medicines were safely administered and checked.

### Is the service effective?

**Good**

The service was effective. Managers had robust systems of staff support, training and supervision in place.

The service was meeting its responsibilities to ensure people had consented to their care and support, and had assessed whether people had the capacity to consent to their care or may be at risk of having their liberty restricted.

People were supported to maintain good health and nutrition through care plans, monitoring and support to appointments.

### Is the service caring?

**Good**

The service was caring.

People told us their staff were kind and caring and family members told us that staff had worked hard to build relationships. Staff had yearly supervisions in ensuring they maintained people's privacy and dignity, and gave us examples of how they did so.

There were systems in place to support people to speak up, including meetings of the tenants association and individual

activities consultations. There was a varied activities programme which involved people who used the service and local community groups.

The provider sought information about people's needs, wishes and life stories.

## Is the service responsive?

**Requires Improvement**

The service was not responsive in all aspects.

Care plans were reviewed regularly, and review meetings were carried out in order to respond to people's changing needs. Keyworking was in the process of being implemented in order to strengthen this, although this was not fully embedded in the service. There were guidelines in place to support staff to respond appropriately where people became aggressive or displayed behaviour which may challenge the service.

Complaints were appropriately recorded and investigated, and the provider carried out work to ensure that people knew how to make a complaint if necessary.

## Is the service well-led?

**Good**

The service was well led.

Managers were visible in the services, and people who used the service and staff told us they were approachable and supportive. The provider had implemented significant changes in the services within a short time scale, including introducing systems of spot checks, audits and an activities programme.

People were asked for their views on the service and appropriate action was taken in response to this feedback. The provider worked well with other agencies to address risks to people and meet their needs.

# Creative Support - Sue Starkey House & Shipton House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place between 18 and 20 October 2016 and was unannounced on the first day. On subsequent days the provider knew we would be returning. We visited Sue Starkey House on 18 and 19 October and Shipton House on 20 October. This inspection was carried out by a single inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we reviewed information we held on the service, including notifications of significant events that the provider is required to tell us about and where people had contacted us to tell us about their experiences with the service. Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

In carrying out this inspection we spoke with nine people who used the service and six relatives of people who used the service. We made observations of people's care and support, including two activity groups. We spoke with the registered manager, a director of the provider, two service managers, a senior support worker, two care workers and a development co-ordinator with responsibility for service user engagement. We reviewed records relating to the care and support of five people, and records of medicines administration relating to eight people. We reviewed personnel records of seven members of care staff,

including information relating to their recruitment, training and supervision. We looked at records relating to engagement with people who used the service, including activities, meetings, surveys and consultations. We also reviewed other records relating to the management of the service, including audits, rotas, policies and procedures and staff meetings.

Requires Improvement

# Is the service safe?

## Our findings

People who used the service and their relatives told us they felt safe. One person said "It is nice and quiet and clean here, I am safe" and a relative said "[My family member] is safe here."

The provider had a safeguarding policy which was being followed, and had an easy read version of this available to support people's understanding. Where abuse was suspected, the provider had fulfilled their responsibilities to record and report this to the local authority and to the Care Quality Commission (CQC), and events had been appropriately investigated. Staff had received recent training in safeguarding adults and were able to describe signs that people may be being abused, and their responsibilities to report their concerns. Staff told us they were confident managers would act appropriately if they suspected a person was at risk. One staff member said "They definitely would take it seriously" and another said "I told my managers they had to investigate and they did. I'd have to whistleblow if not."

Emergency pull cords were available in each room of each flat, and these activated a voice system which came through to staff handsets. Some people we spoke with expressed concern about the response they received. One person told us "It's slightly not working…I used my phone to call them" and another person said "When I called at night I've to wait for a very long time before they come." The provider told us that they had detected a "laid back culture" about response to pull cords, which was highlighted in an incident where staff did not respond promptly. In response to this, they had introduced a system whereby staff had to check a pull cord every two hours. We found that in practice this was usually happening, but there were occasions where up to 11 hours had passed without a check taking place. We also found there was no rotation system to ensure that all pull cords were checked regularly.

We saw that when the service held money on behalf of people they were not carrying out sufficient checks to ensure that people were safeguarded from financial abuse or loss. The provider undertook a comprehensive assessment of people's financial needs when they joined the service, this included a clear definition of the provider's role, recording who held the person's cash, bank records and bank cards, what support was required and whether the person was subject to a Court of Protection order or had their finances managed by the local authority. The provider kept records of financial transactions and receipts, and these were signed off by two staff. However, checks of the balances in the tins sometimes did not happen for several months at a time, and audits were not always taking place regularly. An external audit had recently highlighted this as an issue.

The provider showed us a recent audit of servicing which was carried out on equipment such as hoists and hospital beds which were provided by the local authority. This showed that three hospital beds had not been serviced for between 23 and 30 months, although the manufacturer's instruction stated that these were to be carried out once a year 'as a minimum'. There was also a full body hoist in use which had not been serviced for 20 months although the manufacturer's guidance stated that this should be carried out at least every six months. The provider had correctly detected these issues and had arranged dates for servicing, some of these were carried out the week after our inspection. The provider told us that the local authority had incorrectly recorded this equipment as having been returned when people moved into the

service, and were responsible for contacting them to arrange this. We recommend that the provider implements a system to ensure appropriate checks are carried out in future on equipment and finances to ensure that people are protected from avoidable harm.

There were measures in place to help maintain security. One person told us "security is excellent." Both buildings had CCTV in place, and at Sue Starkey House areas of the building where people lived could only be accessed by using key fobs. At Shipton House there were two locked front doors which could only be opened in person or from people's flats. The provider had carried out risk assessments of the safety of the premises, which required daily checks to be carried out, including checking of communal areas, fire doors, window locks, and checks of fridge and freezer temperatures. These were being carried out daily and signed by two staff, which helped to keep people safe. We were shown copies of satisfactory gas and electrical safety checks for the premises and first aid kits were available and checked monthly. We saw that both buildings appeared clean with new carpeting throughout which was free from trip hazards. Staff were not always wearing identification, but in all cases if they did not they were wearing tabards with the provider's name clearly displayed to identify them as staff.

Staff were undertaking weekly tests of the fire alarm, and ensured that different call points were tested each week. There were daily tests of fire extinguishers and fire doors, and monthly checks of emergency lighting and fire equipment, although fire equipment checks had been missed in September 2016. Servicing records for fire equipment were up to date. The provider had compiled personal emergency evacuation plans (PEEP), which included information on whether people were to remain in their flats in the event of a fire and whether people were able to follow the procedure. These were also held in an evacuation file which contained an up to date list of residents, including people's level of mobility and evacuation procedures. Fire drills were carried out regularly, which included information on whether the building was safely evacuated and whether people had responded appropriately.

All care records we reviewed had a summary of the person's needs for the 24 hour on call manager, and contained a personalised missing person's procedure. This included a photograph, a description of the person and information on their communication needs and understanding of safety and travel.

Risk assessments had been carried out in specific areas where people may be at risk or pose a risk to others. These included people who may be at risk whilst in the community and may display behaviour which could be challenging. This also included medical conditions such as diabetes or epilepsy, risks from smoking and where people may be at risk of self-neglect. All risk assessments we saw had been reviewed in the past six months. They were signed by the person to indicate their agreement and signed by the staff who were supporting them. Where people were at risk, there were risk management plans in place, for example where people were at risk of falling, plans included steps such as using pendant and pull cord alarms to ensure they could call for help.

Where people required the support of staff to mobilise, we saw that risk assessments were in place, and these included detailed guidance for staff about the individual, incorporating guidelines from occupational therapists and instructions on how to use equipment such as slide sheets and hoists. For one person, the risk assessment stated that they could only be moved with the support of two staff; we were advised that this was not current as the person was bed-bound at the time of our inspection.

Where people received support with showering and bathing, the provider had carried out risk assessments including clear guidance on whether the person required support to get in and out of the shower and what aids and adaptations were in place. They also included information about whether the person was more sensitive to variations in water temperature. Risk management plans did not cover people's mobility needs,

but contained steps for how to safeguard people from excessive water temperatures. This outlined a clear procedure for staff to measure the water temperature and record it, and gave clear instructions on what constituted safe temperatures for showering and bathing. We reviewed temperature records for 10 people over a 10 month period, and saw that temperatures were recorded appropriately as being within the recommended range.

Some people who used the service told us that staff appeared stretched, particularly at weekends. One person said "Lovely carers, every one of them, but they're not giving enough time to make lunch. 15 minutes is not enough." A relative told us "[My family member] needs encouragement but there is a lack of interaction at weekends and evenings." This feedback was also reflected in residents' meetings.

We saw that there was an allocations system in place to ensure that people received support from appropriate staff, this included a shift plan and individual rota for each staff member, with a list of people's tasks for the day, and who would require medicines to be administered. We found that in many cases people did not receive the allocated time on their care plans. For example, one person was scheduled to receive 30 minutes support in the morning and 60 in the evening, but in practice received half this throughout the week. Another person was scheduled to receive 30 minutes support in the morning and afternoon, and again received half this. Both these people had two other visits in the day during which they received their allocated support time. The provider told us that they were looking to review staffing levels, particularly at the weekends when more people were at home.

Some people also expressed concern about the level of monitoring during the night. One person said "There is no night check, the last check is 10:30pm until 6:30am." There were waking night staff in place in both services, and some people's care plans included one last check at the start of the night and another in the early morning. These checks were taking place as planned, and several people's care notes contained evidence of additional visits where people had called staff. However, there was not a clear explanation or assessment for the frequency of night checks people received.

Staff files showed that the provider followed safer recruitment processes. Prior to appointment, the provider had obtained a detailed work history with an explanation of any gaps, two references, proof of identification and the right to work in the UK. A check had also been carried out with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. At the end of this process the person's appointment was signed off by a director.

The provider told us that on taking over responsibility for the service, a high number of medicines errors had taken place, and these were notified to CQC. The registered manager told us that they had been working in order to improve staff training and procedures. On joining the service, the provider asked people to complete a declaration of what support they needed with medicines, including areas such as ordering, storage and administration and whether this was done by care workers, the person or their family members. Where people had medicines which were taken 'as needed', there were guidelines in place, and risk assessments had been completed where people were at risk from not taking their medicines.

A recent audit had recommended staff record receipt of medicines on medicines recording charts (MRCs), and this had taken place in recent months. We reviewed medicines records relating to eight people over a three month period, and saw that in all but one MRC medicines were appropriately signed for by staff and suitable notes had been made of when medicines had not been administered. For one person we found two days when medicines were not accounted for. Staff were required to carry out spot checks, including of medicines administration, which in practice took place every two to three days, but these had not noted this

omission.

Audits were taking place of medicines, and these typically covered 10 people per month. This required managers to record whether the MRC was correctly completed, whether it recorded dose, instructions and times recorded. External audits had clear highlighted actions for staff, such as marking discontinued medicines and putting clear instructions in place.

Staff had received training in administering medicines. Additionally, the provider carried out a series of observations of staff competency to administer and manage medicines before they were permitted to do so without supervision. The provider also carried out medicines supervisions for staff, this included reviewing the staff member's knowledge of medicines procedures, and their knowledge of ordering, administering, receiving and returning medicines. These supervisions were due to take place yearly. The provider had implemented improved systems for staff competency relating to medicines.

Good

# Is the service effective?

## Our findings

People were supported by staff who had the skills and knowledge to meet their needs. There were procedures in place to ensure that staff had had adequate training. The provider's audit showed that all staff, including bank staff, had received induction training and training in safeguarding, medicines, moving and people handling, infection control, mental capacity and health and safety. These were the provider's mandatory trainings. All contract staff had also had mental health training and training on dementia. Most, but not all, staff had had training on working positively with older people, although fewer bank staff had attended these trainings, which were considered "added value training" by the provider.

Staff we spoke with confirmed that they had had induction training and shadowing when joining the service. One staff member said "If we need further training we speak with our managers" and another added "They are prepared to help."

The provider had a thorough and distinctive framework for staff supervisions. Supervisions were taking place every month, and involved reviewing the previous month's action plan and recording a general update on any issues staff had experienced. Supervisors then recorded staff knowledge and progress relating to staff's general professional practice, duty of care, person-centred support and inclusion, communication, rights, diversity and citizenship, safeguarding and health and safety. There was then a discussion about the staff member's general wellbeing needs, personal development and training attended, before agreeing goals and actions for the next month.

In addition to this supervision process, managers also carried out themed specialist supervisions each year. This included medicines management, the dignity challenge and safeguarding adults. These tested staff knowledge of their responsibilities and duties in these areas and highlighted areas for development.

The service was working in line with the Mental Capacity Act (MCA) 2005. The Act 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. People had signed their care plans and risk assessments to indicate their agreement to their care and support, and staff had sought permission to retain keys to people's flats and where necessary permission to hold money on behalf of people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had undertaken an assessment of restrictions and deprivation for each person, which detailed whether they may be at risk of having their liberty restricted. These documented whether the person had capacity or required best interests' decisions to be made on their behalf, or whether an application needed to be made to the Court of Protection. These had concluded that nobody using the service was deprived of their liberty.

In one instance we saw that a relative was signing on behalf of a person despite them being assessed as having capacity to make decisions about their own care. The provider told us that in some cases relatives did not understand that they were not able to make decisions on behalf of their relatives without the appropriate authorisation, which was supported by correspondence with family members. The registered manager told us "It's part of the culture that we are trying to change."

Information on nutrition was covered on care plans where people were felt to be at risk. For example, where a person was at risk from complications associated with their diagnosis of diabetes there was information on supporting the person to avoid sugary and fatty foods. For another person, we saw the support plan contained information on what items they should avoid purchasing whilst being supported with shopping. Where necessary, the provider had implemented food and fluid monitoring, these were being regularly and correctly completed with staff in order to address concerns about people's nutrition. We saw that in the period these had been in place, these had resulted in an improved intake of fluids, and one person had started drinking nutritional supplements regularly which helped improve their wellbeing.

For one person, we saw that there was not enough time available to support them to attend appointments. A relative told us "We are called instead." The provider told us that they would seek a review of this person's support hours.

Care plans contained information on how to support people to stay healthy and how best to monitor their wellbeing. People had health action plans in place, which had information on the person's diagnosed conditions, health contacts and healthy eating plans. In some cases, we found that there was unnecessary duplication between the provider and the local authority in compiling these plans, and the provider's health action plans did not always contain clear steps on how to maintain good health. However, there were records maintained of when staff had supported people to attend appointments, and when there were concerns about people's health, the provider had arranged meetings and appointments with appropriate health professionals. There were also hospital passports in place for people where needed. These are documents which support people to access hospital services by providing clear information for hospital staff on the person's health conditions, communication needs and likes and dislikes.

Good

# Is the service caring?

## Our findings

People told us the staff that supported them were caring. One person said "It feels like you're welcome here, and staff and people are so kind to you." Another person said "I'm happy and quite like it here, sometimes you have the odd [staff] brusque and in a hurry, but that's very rare, most of them are very supportive." One person said, "They make it alright, we all get on very well." A relative said to us "My [family member] is safe here, we have tried a few places that we were not happy about. Staff built a relationship with the family, they make a big effort into looking after my [family member]."

People had been supported to complete a personal profile, this included information on what people liked and admired about the person, what was important to them, any concerns they had about their health and mobility and their preferences about how they liked to spend their free time and what staff they preferred to support them. There was also information on what people didn't like, for example one person had written "I don't like it when people do things for me." People were also asked to complete a gender support document to state their preferences with regards to the gender of the staff that supported them.

The provider employed one full time service development officer who covered both services. Their role included engagement with people who used the service and activities. The provider told us that this role was funded by the local authority, and was conditional on evidence of an effective activities programme and engagement with people who used the service.

People we spoke with could recall many activities taking place, pictures of which were on display in the lounge and outside the office. Some activities were led by people who used the service, such as one person who hosted a weekly café and another person ran a weekly quiz. We observed the quiz and saw that people participated well in this. Another person had run an Eid party with the support of staff, and we saw decorations and photographs from this event, which people told us they had enjoyed.

Regular activities were taking place in the service at least daily, these included a seated exercise group, chess, boccia, gardening, takeaway group, bingo, breakfast clubs and darts and film nights. In addition to this, special events in the past four months included a trip to a local pub for curry night, a community safety event, cinema night, barbecue and a tea dance, which was arranged in partnership with a large bank. There was a dementia friends group which was produced with a local hospice, and a local charity called Furry Tales had brought animals to the service for people to spend time with. A community opera group had also performed at the service.

At Shipton House, we saw that the provider had worked with people who used the service to design and build a new, dementia-friendly garden, with a community payback scheme and corporate volunteers helped to build this. This included plants with a strong scent, raised flowerbeds which were accessible to wheelchair users and a sensory area which had boards erected with items attached such as door catches, brushes, doorbells and tools in order to stimulate people's memories.

There were regular cooking sessions taking place at Shipton House, and we observed that although only

one person attended, they received support to cook the meal of their choice. The development officer told us that they had started reminiscence bakery sessions, whereby people brought memories and ingredients which reminded them of their childhood. The provider told us "this is a very sensory experience, it brings back memories."

The provider recently started compiling an experience audit from activity sessions on what went well for people, who had attended it, and individual feedback from people who attended. Staff had arranged a visit to a local museum that had developed a self-guiding tour basket to support people with dementia to fully access the museum. People who used the service were given the opportunity to try this out, and staff assessed whether it improved their experience visiting the museum, which was shared with museum staff after the visit.

Staff supported older people and people living with dementia to carry out life story work. These documents were based on a template provided by Dementia UK, and were well completed with good levels of detail, including information about the person's job, holidays, family life and childhood. The life story groups had been arranged with the local occupational therapy team in order to draw up a protocol for the group, which linked to good practice guidelines, inclusion and who may be excluded from the group, and informed facilitators that people should only be encouraged to share what they wanted to, and that staff should be prepared for people becoming upset if difficult topics were discussed.

We observed a group which was facilitated by the service development officer. The member of staff ensured that people were comfortable in their environment and served refreshments of people's choice. The discussion was of a good humoured nature, and people were supported to take the lead and share experiences. Some people reminisced about their summer holidays, whilst other people shared more difficult memories, which encouraged other people to do the same. The member of staff told one person "You can see you weren't alone in that." At one point, a person left the activity, and the staff member saw that the person was upset and left the group briefly to reassure the person and offer comfort and support. The staff member then returned to the group and reminded people that some topics could be upsetting and they shouldn't feel under any pressure to share. A staff member told us "It's about building a relationship and finding out how to help the individual with their memory."

Staff maintained records of when people attended activities, and this was used to highlight when people were not engaging with activities. This was used to arrange individual consultations with people on what activities they would like to do, and putting in place an activity timetable for the person. Staff told us "We are trying to reach everyone." One younger person who used the service told us "It would be nice to go out with people your own age."

Forums were taking place in order to support people to speak up. These included an event forum and meetings of the tenants association, which the provider had helped people who used the service to set up and lead. These meetings discussed activities and allowed people to feedback on what they had enjoyed and what they would like to do in future. The tenants association had discussed their concerns with managers about their staffing, to which managers had introduced a new shift rota and a key working system. People had requested a weekly activities timetable, which was now in place and being delivered every Friday. Other topics covered in these meetings included the use of volunteers, repairs issues and financial arrangements. At Shipton House, residents meetings were also taking place monthly, and topics covered included repairs, fire alerts, evacuation plans and activities.

All staff had discussed dignity and privacy as part of their yearly 'dignity challenge' supervisions, where they had been asked to provide examples of how they ensured they showed respect to people, treated people as

individuals and promoted choice and control, privacy and ensured that people were able to complain. At Shipton House, the service delivery manager carried out observations of how people had maintained privacy and dignity whilst providing personal care. Staff gave us examples of how they did this, for example by knocking on doors and giving people time to respond, and by asking people what they needed. A staff member said "I make sure I give people the ability to make decisions about their care." Another staff member said "When you love your job you have to give it your all."

Requires Improvement

# Is the service responsive?

## Our findings

People received care and support that met their individual needs. Care plans were reviewed at least every six months. Reviews also took place in response to particular events or changes to people's needs and covered areas such as appointments, independence or unmet needs. They were also used to review people's progress and strengths and record if any further action was needed such as referrals to occupational therapists or social worker input.

However, we found that in some cases care plans did not accurately reflect people's current needs. For example, one person's plan said that they needed support with medicines, breakfast and personal care in the morning, but logs of support provided showed that the person was now only receiving support with medicines. The provider told us that this person's needs had changed due to increased independence, they had carried out an internal review but were awaiting input from the local authority before they could update their care plan. In another case, it wasn't clear that the person had enough support hours to support them to attend appointments.

The provider used a personal profile which was designed to meet the needs of people living with dementia. This included information on the person's preferred name, things they'd like for staff to know about them, current and past interests and routines that were important for them. They also contained information on things that may upset the person, their communication skills, mobility, sleep patterns and routines, and nutritional needs. Where people displayed behaviours that were aggressive at times or behaviour which may otherwise challenge the service, we saw that there were guidelines in place on how best to de-escalate and calm the situation, and staff recorded what they had done in those circumstances.

The provider had recently introduced a system of key working, which they told us was in addition to what was contractually required by the local authority. Everyone had an allocated key worker, and all care files had records of at least one key working session. Key working sessions covered areas which were relevant to the person, for example one person had discussed their financial support, day activities, health needs, cooking and laundry. Key working sessions were yet to take place regularly, and although most discussions were relevant and person centred, in one case records did not seem to record a discussion with the person, and had replicated parts of the person's care plan.

Key working sessions concluded with an action plan for the person and the key worker to follow. These were not always specific or measurable, for example one person's plan stated that their goal was 'not to be aggressive or upset', without recording further steps for how this could be achieved, and there was not a clear system for recognising people's goals or support they required to do these. However, where people had achieved a personal goal this was recognised and celebrated by the provider, who provided a certificate titled 'I reached my goal.' These recognised achievements such as learning to travel in the local area independently or engaging with other people through attending activity sessions or tenants meetings.

The registered manager told us about how they had worked with a person who was previously homeless for a number of years. They had supported this person to achieve better communication and engagement with

staff from the provider, and they had now fully settled into the service and were no longer on the streets.

The provider had a complaints procedure and policy in place. Where complaints were received, the provider had investigated and where necessary had taken disciplinary action against staff and carried out changes in their internal procedures. Where appropriate, the provider had apologised to people who had complained. There had been no complaints recorded at Shipton House, but the provider had carried out a survey of people who used the service to ensure they did know how to complain, and where people had stated they didn't, this was appropriately followed up with people. The provider also maintained extensive records of compliments they had received, these particularly concerned the quality of the activities programme and praised staff interactions with people's relatives.

Good

# Is the service well-led?

## Our findings

People told us they felt the service was well-managed. One person said "It is excellent here, well-managed and approachable" and a relative said "Where my relative was living before it was dreadful but I don't have any bad things to say about here." Staff told us "I get the support I need from my managers" and "They give you the opportunity to speak out about things." People we spoke with knew the managers well, and managers were a visible presence at both services. At the time of our inspection, the area manager was the registered manager, with a service delivery manager responsible for each service, but the provider told us they intended for one of the service delivery managers to take this over once they were ready.

The provider told us they were trying to encourage staff to take responsibility for promoting good quality care. They had introduced a system of spot checks, and records showed the staff team carried out around 20 spot checks each day. These were used to check medicines, the person's welfare, their bed and fridge, and checking their flats for hazards. In practice, this meant that these were carried out every two or three days. Staff were also encouraged to think about how they met Care Quality Commission (CQC) requirements, and were asked to note recent activities they had carried out and how these aligned with key questions. For example, staff fed back that they had promoted safety through carrying out medicines checks and responsiveness by carrying out a visit to the library in response to a person expressing a wish to go there.

Managers had carried out a survey in June 2016 in order to gauge people's opinions of the service and their experiences. These revealed that most people were happy with the service, and in response managers arranged for more exercise sessions and days out, and to have a consultation on activities and arrange for work to be carried out on the garden, which had taken place. The provider also produced a regular newsletter for all users of the extra care services in the borough, this included advertising events that were taking place, updating people on the provider's activities, activities that people who used the service had taken part in and providing guides to the local areas.

When people joined the service, managers used a screening tool to understand where people using the service fitted into statutory frameworks, for example if people received funding from the local authority or were subject to treatment under the Mental Health Act (1983), what type of accommodation they had come from and whether there were areas of risk to consider, for example if a person was subject to Multi-Agency Protection Panels or an Anti-Social Behaviour Order.

The provider had taken over responsibility for the services in January 2016, and had implemented systems to maintain the quality of care, such as spot checks, audits, supervision frameworks and training, and had developed a detailed activity programme in a period of a few months. Several incidents relating to medicines errors had been reported when the provider had taken over the service, but we saw that this had significantly improved in a short space of time.

Where people were refusing support and were at risk, we saw evidence of how the provider worked with the local authority and other agencies to address risks and arrange the support and services which the person

required.

Staff appraisals had been carried out for all staff. These looked at essential behaviours and key competencies, in line with the provider's key values. This included assessing staff's professional practice in line with their duty of care, how people's rights were promoted, equality, diversity and citizenship and health and safety. It also reviewed significant achievements and challenges which had occurred in the past 12 months and concluded with an action plan for staff, with measures such as training to support staff development.

Team meetings were taking place on a monthly basis in both services. These covered areas such as forward planning, ensuring regulatory compliance, health and safety, medicines policies, finance procedures and spot checks. These were used to ensure that staff understood their responsibilities to carry out audits and implement keyworking.