ADULT SOCIAL CARE

SERVICE SPECIFICATION APPENDIX 2 - QUALITY STANDARD ASSESSMENT
Community Home Care Providers
Self-Assessment Tool
2015

SECTION 1 – BUSINESS MANAGEMENT, GOVERNANCE AND RESOURCES

These overarching developmental standards give a broad framework, which will support home care service providers commissioned by Adult Social Care to improve services continually, and to shape future services which will deliver safe, quality driven, effective care and support for service users. These standards will help service users experience a consistent quality of home care services, irrespective of the homecare provider, that will protect them from incidents of avoidable harm and help them to get the best outcomes from the services they receive from the provider.

Standard 1: Leadership, Management and Accountability		
The organisation has strong leadership, a clear strategic vision and effective governance, including assurance and auditing systems or processes necessary to ensure service users get the best from their home care services.		
Standards		**Sources of Evidence**
The responsible person/ manager of the services provided in Leeds has the qualifications, competence, skills and experience necessary for the post and is a registered manager that holds and has completed full registration with CQC.	1.1	The registered manager must hold an up-to-date CQC certificate of registration (or confirmation in writing that the responsible person's application is currently being processed, and was submitted within 3 months of start date).
	1.2	The responsible manager must have achieved or be working towards obtaining Level 5 Diploma in Leadership in Health and Social Care, (or equivalent). Evidence must be submitted for validation.
	1.3	A Disclosure and Barring Service (DBS) check has been carried out in the last 3 years and the reference number can be provided. It is in date and has been refreshed within the last 3 years.
	1.4	An accountable senior member of staff is contactable at all operational times.
	1.5	The responsible manager/person is able to evidence they have experience/training and/or a working knowledge and understanding of people with personal care needs, for example, people with physical or sensory impairments, learning difficulties, mental health problems, long term conditions or who may need end of life care. They have an understanding of the personalisation agenda in promoting choice and control.
	1.6	All staff, including the responsible manager/person understands and promotes the development of integrated working, and evidence supports that there is collaborative working OF STAFF with other agencies and professionals in the delivery of home care services.

There are clear reporting and accountability mechanisms in place and these are understood by all staff, which have been tested through an internal audit process and a risk analysis should be undertaken in respect of service users, staff and organisational reputation. Actions to mitigate risks should be identified and implemented and all risks should be reviewed (interval to be specified)	1.7	Agreed key performance indicators (KPIs) are in place to enable internal and external assessment of the operational and financial performance of the organisation, with follow up action taken where required with relevant reports/minutes of meetings available.
	1.8	The roles and responsibilities of the manager and senior staff are clearly defined, and performance is monitored VIA a performance management processes through a structure of line management
	1.9	There are management policies and procedures, and the necessary training undertaken to implement policies effectively, which prepare and support staff in carrying out their role effectively, and develop their potential and ensure good practice in service delivery.
	1.10	A process for continual staff development exists that encourages staff and managers to jointly identify learning needs, and ensures accountability and quality commitments are met more effectively.
	1.11	The organisation encourages improvement and innovation in the delivery of home care services to better meet service user's needs, including the adoption of national initiatives and guidance.
	1.12	Any changes to service provision are subject to agreed systems of change management with SU agreement– communication is effective, training programmes are implemented to ensure staff are competent to provide changes in service delivery following service reviews, and both staff and service users are involved in the changes implemented, for example, organisational changes.
	1.13	There is a business continuity plan in place that is reviewed annually to accommodate any changes that may affect the continuation of service provision.
	1.14	Contingency plans for the home care service include provisions to ensure continuity of services, if key members of the staff team are not available.
	1.15	The responsible manager/person is trained and skilled in emergency planning and ensures all key staff are trained and made aware of what to do in the event of an incident.
	1.16	Risk control measures are appropriate in respect of the business and organisational reputation, and are appropriate in respect of the provision for the range of services provided.
	1.17	There is a regular review of the effectiveness of risk control measures, including the risk for service users and staff.
	1.18	The organisation has implemented a systematic and robust approach to audit; with a responsible person or persons identified this should include regular sample audits of all care notes/logs documentation. It must also include 'spot check' visits and service user feedback (although service users should be given other opportunities to provide feedback as well
	1.19	The organisation must be able to evidence that l checks are carried out on all forms of communication with both staff and service users to ensure communication is effective and is responded to appropriately. The organisation is required to evidence how it ensures information held on record is up to date, for example telephone numbers and contact details.

Standard 2: Workforce Development and Resources		
The organisation has an effective performance management and personal development planning process linked to workforce planning.		
Objectives		**Sources of Evidence**
There is a rigorous recruitment and selection procedure which meets the requirements of legislation, equal opportunities and anti-discriminatory practice and which ensures the protection of service users and their relatives	2.1	There is a systematic approach to determining the number of staff and range of skills, to meet service demands, consistency in service provision and to ensure quality and safety for service users.
	2.2	Staff recruitment and the induction process for all new personnel focuses on promoting the intrinsic value of each service user; and ensure the values of each member of staff are consistent with this message.
	2.3	All managers and staff are provided with a written job description, and person and work specification identifying their responsibilities.
	2.4	There is an appropriate process in place that ensures and confirms that the individual holds the required qualifications, competence, skills and experience for the position they are applying for, and as stated on their application form/CV.
	2.5	All staff employed who provide a regulated activity as defined by the Safeguarding Vulnerable Groups Act 2006 must have been checked by the Disclosure and Barring Service (DBS). A current reference number for all staff and successful applicants who have not commenced work must be provided as evidence of compliance and adherence to this regulation. All DBS checks must be renewed every 3 years for all existing staff.
	2.6	There are robust risk assessments (and where applicable, risk management plans) in place for staff that have either a conviction or caution recorded on a DBS certificate.
	2.7	There is a written policy on the recruitment of ex-offenders, which is made available with all DBS applications at the outset of the recruitment process.
	2.8	There is a process in place that ensures newly appointed staff are not scheduled to work prior to the completion of the DBS check and receipt of a DBS certificate.
	2.9	The recruitment process ensures two appropriate references are obtained and validated before staff commence employment. References must be from previous employers (or where no employer references are available, from other professionals) and are recorded and available in staff files for inspection.
	2.10	The recruitment process looks at all employment gaps for all applicants.
	2.11	The recruitment process and pre-employment checks in place must confirm that the applicant is able to work in the UK.
	2.12	The working time directive states that no staff member can work over 48hrs a week regularly. Any deviation from this directive must be on record and the risk to the staff member must be assessed, and if accepted, the risk

		management form must be signed by the staff member and held in the staff files.
	2.13	There is an effective process to carry out exit interviews with all staff that terminate their employment, which is analysed and reviewed by senior management and held on record for inspection.
There are written policies covering equal opportunity (EOP), anti-discriminatory practice (ADP) and harassment that cover employment and service delivery.	2.14	The equal opportunities policy is reviewed every 3 years, or as and when legislative or regulatory changes occur, in line with the Equalities Act 2010 or any other future acts of parliament that supersede this.
	2.15	The policies are in accordance with the Disability & Equality Commission Code of Practice (Commission for Equality and Human Rights from October 2007).
	2 16	The organisation has its own equalities strategy to meet the changing demographics of the Leeds population and to deliver services to diverse communities.
	2.17	A documented equalities action plan is available for inspection, detailing key objectives, targets and timescales and is reviewed on a regular basis.
	2.18	The equalities data sets targets to address gaps in the recruitment of staff representative of black and minority ethnic (BME) communities. The data is continuously reviewed and relevant staff are informed and updated in respect of the targets and any changes.
	2.19	Staff involved in recruitment and selection have undergone equality and diversity training.
	2.20	Recruitment procedures state that data is collected on successful and unsuccessful applicant's ethnicity, age, gender, disability, faith and sexual orientation and fed into the equalities strategy.
There is documented evidence that confirms comprehensive guidance and support is provided for all employees to ensure best practice in the provision of safe, good quality and effective home care services	2.21	All employees must receive a comprehensive staff handbook, containing information on the conditions of employment, policies and procedures, and information on good practice within their Organisation to ensure the delivery of safe services and best practice.
	2.22	Team meetings (should be scheduled to support attendance and that safeguarding, complaints and good practice in health and safety are discussed and are standard items on the meeting's agenda.
	2.23	Risk management processes should evidence that an appropriate health risk assessment has been carried out on all existing staff and should be held on staff files for inspection.
	2.24	Special attention is paid to the risk of lone workers. A lone worker policy sets out the procedure to minimise the risks to people working alone.
	2.25	The Service Provider will ensure there is a documented risk assessment addressing the potential for staff to benefit personally when working with vulnerable people (including but not limited to handling service users' money, provision of financial advice, power of attorney, wills and bequests) - and procedures in place to minimise the identified risks.
	2.26	The Service Provider will ensure that service users are consulted prior to new members of staff who are work shadowing colleagues attending their support visits.

	2.27	Disciplinary procedures address missed visits, inappropriate behaviour, poor performance and gross misconduct.
	2.28	There is evidence that all information, contact details and telephone numbers in respect of all staff are kept up to date, and are checked periodically to confirm that the information held on file is current and all staff are contactable, in line with data protection regulations.
The service delivery workforce is planned and appropriately resourced in order to support service quality, productivity and safety.	2.29	There is a plan for reviewing, developing and funding a home care workforce that optimises skill mix and meets the changing needs of the service.
	2.30	Appropriate workforce planning should take place and where deficiencies or shortfalls in the workforce are identified a corrective plan is put in place.
	2.31	Staff who compile the work rotas should be competent and skilled in this role, and ensure wherever possible, that service users receive support from the same consistent staff.
	2.32	To ensure consistency in service delivery the number of staff scheduled to provide an individual's services is kept to a minimum as necessary. Staff should have a good knowledge of the needs of the service user and the services they require to support them to live independently in their home.
	2.33	There is evidence to support that the organisation and all of its staff are aware of, understand, and put into practice the "Skills for Care" code of practice, which promotes and upholds the privacy, dignity, rights, health and wellbeing of people who use care services and their carers at all times.
	2.34	The organisation can evidence that additional measures are taken during peak holiday times, high levels of sickness or unexpected absences, to ensure all services are covered.
Opportunities to increase knowledge, skills, training, induction and on-going learning and development are provided for all staff and volunteers (as appropriate).	2.35	There is a comprehensive training and skills learning programme in place that ensures all staff receive mandatory training as appropriate to their role and the services they are providing. This should include, but not be limited to, safeguarding, manual handling, complaints, diversity and good practice in person centre care and medication. A corporate training plan is developed and discussed at supervision and appraisals with all staff members, and is held on file for inspection.
	2.36	Staff receive regular feedback about their performance in their role and any training, learning and development needs are identified and supported.
	2.37	All training programmes used are reviewed and adapted to ensure that they remain fit for purpose, which includes working towards / achievement of QCF) / accreditation and other professional standards at all levels.
	2.38	Training records are maintained for mandatory and role related training. Regular competency assessment is in place and revalidation and refresher training is provided if necessary.
	2.39	There is a structured induction process which encompasses the Skills for Care Common Induction Standards (or equivalent) which prepares new staff for their role, and encourages and supports an enabling culture rather than service led culture. The induction programme for all new care staff must include the Skills for Care - common core principles to support dignity in the Adult Social Care sector.

	2.40	All staff members are supported by Management to be aware of their own level of competency and know how they can develop in their roles and careers. Processes are in place to identify and manage staff members who fail to reach minimum competency or performance standards.
	2.41	Following a programme of work shadowing with a competent member of the staff team, all new staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out necessary care tasks, this must have been signed off by an authorising officer
	2.42	Staff files in respect of training records and supervision notes confirm that, where applicable, training to increase knowledge and skills in services provided to meet complex needs, including guidance and competency signoff by the appropriate professional, for example, district nurse team.
	2.44	The organisation must not act in a manner which prevents or limits or would result in staff not obtaining further qualifications or specialist training appropriate to their role and within the planned training budget.
	2.45	There is evidence on service user's files that confirms consent is obtained before any "on the job" training takes place in the service user's home.
There is a performance management process in place that is audited periodically and monitors that staff supervisions and appraisals are carried out, and the documents used are designed to a high standard and have the mechanisms to monitor staff competence in core areas of service delivery.	2.46.	There is documentary evidence that supervisions specifically address the nature and limits of relationships between staff and services users, and maintains service user dignity, and includes discussions on the following: • Safeguarding • Service user feedback/complaints (IN PLAIN ENGLISH) not to have smiley/unhappy faces) • Personal development • Good practice in moving and handling/medication • Service users finances (where appropriate) • Travel time • Risk – lone worker identified • Service user's well-being, for example, nutrition. monitoring skin for pressure sores (where appropriate) • Relationships with other professionals • Professional recording in care notes • Work life balance
	2.47	Supervision records held on staff files evidence that a minimum of four face to face supervisions have been conducted in any given year, and include an observational supervision. In addition to this a minimum of four spot checks have been carried out in a service user's home in any given year. Staff files should evidence an increase in spot checks where a concern about the staff member has been reported to the office.
	2.48	Staff files evidence that all staff have the opportunity to speak with / meet with a line manager at their request should the need arise, for example to share concerns, debrief after a particular event or to discuss personal wellbeing.

SECTION 2 – SERVICE DELIVERY FRAMEWORK

Adult Social Care's Quality Standard Assessment (QSA) sets the standards and quality expected in the delivery of home care services, and is a means of ensuring that providers deliver services to national standards and in accordance with contractual expectations.

Standard 3: Personal Support Needs and Risk Assessment		
The fundamental principle of the risk management process is to ensure that individuals receive personalised care/support that meets their needs, regardless of their disability, age, gender, ethnicity, religion or sexuality; this applies to people with a particular medical or psychiatric diagnosis. This support must exist within a framework of risk assessment and risk management that is collaborative, involving carers, family and/or other professionals.		
Objectives		**Sources of Evidence**
The needs of service users and any inherent risks are assessed on a consistent and comprehensive basis prior to a service COMMENCING, (or in the case of an emergency within 5 working days) or very shortly afterwards as appropriate to the needs of the client group.	3.1	The needs and risk assessment process is written down and is reviewed in response to changing legislation or contractual requirements and staff can describe the procedures that are followed.
	3.2	There is a needs and risk assessment tool appropriate to the service user group; it is periodically reviewed to ensure it gives appropriate guidance for support staff and meets individual's personal needs, personal preferences and, when it applies, their complex needs. The document minimises restrictions on service user's freedom, choice and control and, where applicable, the service user's mental capacity has been taken into consideration and guided by the Mental Capacity Act code of practice.
	3.3	The needs and risk assessment document(s) identifies and covers all risks i.e. risk to self, risk to others, risk from others. However the following must be considered when conducting a risk assessment: personal safety and risk, medication, advocacy support, sensory impairments, cultural/faith needs, mental health and nutritional and hydration support needs. The risk assessment tool used must evidence that it fully considers and gives guidance on the service user's emotional wellbeing and any personal history that may have an effect on their health and general wellbeing e.g. reasons for service user's good days and bad days.
	3.4	The staff induction and/or training plan incorporates the needs and risk assessment procedure, and how this is monitored in the provision of services and general observation by care workers, in the course of carrying out their duties.
	3.5	Copies of all assessments are kept on file in the office and are available for inspection.
The needs of service users' and identified risks are reviewed periodically on a consistent and systematic	3.6	Service users' file notes show that all service users' needs have been reviewed with appropriate frequency and at a minimum of at least annually.
	3.7	Service users' file notes show that risk assessments have been reviewed with appropriate frequency after a particular incident, and/or each critical incident, for example, a long stay in hospital.

basis Needs are reviewed as the service users' circumstances change or as a result of an incident or as a result of a service user request. Needs and risks should be reviewed as a minimum on an annual basis to be compliant with CQC's fundamental standards.	3.8	Reviews are diarised, recorded and systems trigger a review date, annually and in accordance with the CQC fundamental standards. Staff supervisions take into consideration the risk management process, to ensure risks are being monitored and reported when staff have concerns, or have identified any changes in a service user's circumstances, needs, or their health and wellbeing.
Needs and risk assessment and reviews involve service users, and take full account of their views and their own personal targets, and aspirations The guidance and assistance of professional expertise is available when necessary.	3.9	All assessment documents are agreed, signed and dated by both the service provider staff and the service user (where the service user is unable to sign for any reason this is clearly recorded on the documents used), as well as any other professional present at the review/assessment.
	3.10	Service users are provided with a copy of their assessments and reviews in an appropriate format (including translated where applicable). There is documentary evidence (correspondence, etc.) that external experts are available to participate in assessments when necessary, for example, interpreting services.
	3.11	Assessments take into account service users' individual goals and aspirations, and personal preferences.
Assessment and review procedures are reviewed periodically and in response to changing legislative or funding requirements.	3.12	There is documentary evidence that the risk assessment procedures have been reviewed and/or updated within the last three years (or more recently if required by external factors).
Staff carrying out needs and risk assessments and reviews are competent to do so, and support staff have been appropriately trained to meet the personal needs of the service user.	3.13	Training records and/or personnel files show that relevant staff have been trained in needs and risk assessment (including risk management) including how to conduct periodic reviews according to the risk priority and the recommended time period of the planned reviews based on the risk level identified for the service user, and or staff delivering services.
	3.14	Personnel files show that staff undertaking assessments and reviews are experienced and skilled in working with those needs most commonly encountered amongst prospective service users, including personal needs e.g. sensory impairments, culture and faith requirements, physical disabilities, learning disabilities and functional and organic mental health illness.
	3.15	Completed needs and risk assessment documents are accessible to support staff and are written in a way that clearly states what the service users' needs are, what the associated risks are and how risks are to be managed to promote and enhance safe working environments.
	3.16	Support staff are fully informed of the risks involved and how to minimise and manage these risks before

		commencing care tasks and if necessary training needs have been identified and implemented.
Outcomes of assessments and reviews are explained to service users.	3.17	The written procedures state that decisions following all assessments and reviews must be explained fully to all current service users as standard practice in a sensitive way (and, where applicable, families/their carer(s)).
	3.18	Needs and risk assessments balance the duty of care with the promotion of independence and positive risk management that reflects the risk and allows service users to have the ability to be in control of their own lives.
When service users give permission, outcomes of assessments are explained to the relevant ASC Team.	3.19	Documented evidence confirms Adult Social Care (ASC), care managers or social workers have been involved in or have been copied into the outcomes of assessments as appropriate If it is agreed that the support provided has sufficiently improved the service user's ability to support themselves and has reduced the support needs required; records held on file confirm a reduction in the service has been reported to the service user's social worker (if known) or to ASC for a change in the required services/outcomes recorded in the service user's Individual Service Agreement (ISA) document as appropriate.
The service takes a proactive approach to involving families and other agencies in its work that includes trying to establish stronger links or more regular interaction with key agencies such as social workers, GP's, district nurses	3.20	Correspondence or minutes of meetings demonstrate inter-agency liaison, which benefits the service user(s).
	3.21	There are named contacts in all of the key agencies and examples of regular information sharing/involvement, of service user's families, advocates and practitioners from a range of services and organisations which help to improve the quality of risk assessments, risk management and decision-making.
Feedback is periodically sought from key agencies as part of the strategic service planning in respect of the overall service review, and as part of a continuous improvement programme.	3.22	There is an internal quality review / monitoring procedure in place to obtain feedback from other professionals (e.g. ASC care management teams) and it is used in an appraisal of how safe the services are, and the quality standard and effectiveness of the risk management process in place.
	3.23	There are minutes, reports or other documents that refer to feedback (service users /family/stakeholders/other professionals) being incorporated into service planning and service reviews.
Outcomes of reviews (of individual needs and risk assessments) across all commissioned services are used to inform service development and strategic planning as part of a continuous improvement programme.	3.24	Reviews of the support needs processes consider how successful the service has been in assisting service users in realising their plans, targets or aspirations and this information is used to improve services to all service users. The organisation can evidence that service users have benefited from the services provided, and planned annual training programmes are reviewed in line with service improvement, and changing needs. The organisation must be able to provide examples of the changes implemented as a result of strategic planning within a continuous improvement programme.

Standard 4: Personalised Care and Support		
The care and support planning process embraces the principles of independence, choice, inclusion, equality and empowerment as the foundations of service provision and supports service users with dignity and respect to live fulfilled lives, making the most of their capacity and potential. Person-centred planning puts the person at the centre of the care and support planning process. The development of the documented plan should be formed by the express wishes and preferences of the individual and their eligible personal needs. Care and support plans should be creative, and place service users' views at the centre, be managed by skilled competent staff and involve their carer(s), family and/or other professionals. Care and support plans should be flexible and responsive to changing needs and changes in the individual's health and emotional wellbeing.		
Objectives		**Sources of Evidence**
There is a policy and written procedures in place that go beyond statutory requirements to embrace good practice and these are followed by staff.	4.1	The policy and procedures comply with any statutory requirements, are easy to understand and user friendly for service users' and staff. The policy document makes reference to legislation that underpins good practice in care and support planning (Care Act 2014); and complies with the service specification that underpins the conditions of the agreement with the Council and is reviewed in line with changes in legislation and/or every three years.
Where they are able, service users or their representative give valid consent to the care and support they receive. Service users understand and know they can change any PLAN that has been previously agreed about their care and support. Their human rights continue to be respected and are taken into account.	4.2	Comprehensive guidance on the support planning process is provided in plain language in the organisation's service user's handbook/guide to service provision. The guide informs the service user what they can expect from the organisation and informs the service users/family advocates that they have the ability/right to ask for a review of the agreed plan. Service users/their Carer/advocate must give consent to the agreed care and support plan,
	4.3	If the service user is unable to sign the agreed plan (whatever the reason), this must be duly recorded on all the service user's records held on file in the home and in the office. Service users must be informed in writing (handbook) and reminded periodically that they **must** sign (if they can) the care notes/logs that confirm that the services that meet their needs agreed and developed in the care and support plan have been provided to their satisfaction.
	4.4	Comprehensive guidance on the support planning process together with the relevant policy and procedures is provided for staff in staff handbooks, and ensures services are delivered with compassion and in accordance with the service user's human rights (Human Rights Act 1998).
	4.5	Appropriate training and guidance ensures staff know and understand when to obtain consent, when to take verbal or implied consent and how to document records of consent and are able to discuss and explain the risks, benefits and alternative options to the way services can be delivered in line with the Mental Capacity Act code of practice and the guidance on deprivation of liberty safeguards. Where it is necessary, the organisation can evidence that they have supported the services user to access advocacy services to help them make informed choices.

	4.6	There are appropriate systems and arrangements in place to monitor practice around consent and capacity and to regularly review a service user's ability to give consent (as appropriate)
All service users have individual outcome focused care and support plans that address the needs and risks identified by the needs and risk assessment process and have been constructed to support service users to experience appropriate, effective care and support, in an enabling way, that safely meets their needs, protects their rights and maximises their independence, health and wellbeing.	4.7	The care plans exist and copies are placed on service user case files, and in the service user's home.
	4.8	Care plans are stored in the service user's home and are accessible to relevant staff, other professionals and the service user (unless there are clear and recorded reasons not to do so).
	4.9	Clear links can be seen between assessments of service users' needs and associated risks as identified in the Individual Service Agreement (ISA) and their needs and risk assessments documents held in file.
	4.10	The service complies with the Data Protection Act 1998 and any subsequent legislation.
	4.11	There is an up to date confidentially policy in place.
	4.12	Staff induction and training programmes cover the Confidentiality policy and files are available for inspection.
	4.13	Staff have signed and dated a confidentiality statement and evidence is available on the individual staff files for inspection.
	4.14	Confidential information is transmitted and stored appropriately by the branch and staff working outside of the branch, and there is a system in place to check and monitor this is fully complied with.
	4.15	Staff are made aware of the consequences of breach of the policy, including taking legal or disciplinary action if appropriate, and terminating employment.
	4.16	Service users or their carer/family are advised on the Confidentiality and Data Protection Policy.
	4.17	Support staff must take into account the life experience and personal preferences of service users when planning and delivering any care. Personal life experience must be documented by the assessor assist staff to better understand their service users and their personalities and the dignity they deserve in the services provided Support staff are skilled and practiced in respecting that service users have lived valued lives, contributed to the society and communities in which they live, have worked in skilled employment, were young, fit and able bodied, have been/are married/lived with partners, brought up families and have mature life skills. Support staff understand that the use of over familiar terms/language for example, "dear", and "luv" is not acceptable

The care and support plan has encouraged and supported the service user in setting goals to help maximise their independence and improve the quality of their life.	4.18	Care and support plans are clearly understood by the service user/family/their carer/advocate and evidence the service user's ability to continue living independently in their own home; there are clear preferences identified in the care notes/service log that confirm that the support staff promote and encourage independence rather than dependency.
	4.19	Staff members completing the care and support plan are sensitive to the diverse and personal needs of service users and this is reflected in the content. Any other related documents confirm that the service user's spiritual, intellectual, emotional and social needs have been considered and documented as appropriate.
	4.20	Care plans incorporate specific intended outcomes which have been agreed with service users, and if appropriate, their carer, relatives or other advocates.
	4.21	There is documentary evidence (correspondence, protocols etc.) that external agencies/experts are available to participate in care and support planning (and reviewing) when necessary.
	4.22	Quality assurance processes can confirm that service users feel that services are delivered with dignity and respect and treat service users as individuals; are sensitive to their needs, respect their right to choice and control, and in doing so, assist them in maintaining confidence and their self-esteem, and support their ability to remain in contact (where possible) with friends and family and the wider community in which they live.
Service users are enabled and supported to have a choice of nutritional and balanced food and drink to meet their diverse needs and personal preferences.	4.23	Training records confirm that support staff who are involved with food preparation have completed an up-to-date food and hygiene training, are knowledgeable and have an understanding in respect of cultural food preparation. Support staff that are requested to cook a hot meal have the experience and skills to cook a nourishing, edible, hot meal to the service user's preference and taste.
Care and support plans support service users to make healthy dietary choices and lead healthy lifestyles and provide access to information about a healthy and balanced diet.	4.24	Care notes/logs are audited to ensure food intake is regular and at the planned times for maintaining a good healthy diet, and is provided at critical times to support medication management and good diabetes management for service users. Quality assurance processes ensure service users are happy with their food choices and check how care workers ensure food is in date and suitable, before it is cooked/served to the service user. Where any concerns are noted by the care worker in respect of their diet then this is reported to the relevant professional agency (e.g. social worker, dietician)
Only experienced, competent, trained staff will support service users to create and develop a personalised care and support plan that ensures the safety of the service user.	4.25	Training files evidence that staff are experienced (or trained) in working with personal care needs most commonly encountered amongst service users and have an understanding of personal needs e.g. sensory impairments, learning disabilities, physical disabilities, mental health and nutrition.
	4.26	Training files evidence there is a variety of staff training and skills learning opportunities targeted to meet the needs of the service users. This must include an understanding of working with and supporting service users diagnosed with functional mental health illness or organic mental health illness. All staff completing care and support plans have attended customer care training and effective communication training prior to working with service users.

There is a process in place to regularly review the effectiveness of care and support plans and that these are kept up to date to support the changing needs of the individual.	4.27	Review records demonstrate links between changing need, revised user outcomes and care and support plans
	4.28	Review records confirm that the appropriate staff assess the risk of harm to the service user, including environmental risks, and ensure that this is effectively managed and reviewed regularly to keep the service user safe
	4.29	The provider ensures that reviews are responsive to service users' needs and involves the service user, and with the service user's permission, family, their carer, advocacy (if necessary) and where appropriate a representative from ASC.
	4.30	Evidence on file confirms any changes to the care and support plan have been documented, the service user (where possible) has signed and staff scheduled to support the service user have been informed and have understood the changes.
	4.31	Evidence on staff files confirms when training needs have been identified due to changes in the service user's circumstances. Training has been completed by all staff scheduled to support the service user.
	4.32	Staff are proactive in identifying and reviewing changing needs and risks.
Support staff are given the right information and tools to enable them to follow the care and support plan, and are confident to do so.	4.33	Staff are trained in the care and support planning process, including how to read and follow a care and support plan and have signed the plan to confirm they have fully understood it.
	4.34	Care and support plans are accessible to the support staff and written in a way that clearly states the support services to be carried out and the individual outcomes to be achieved.
	4.35	Care and support plans are read and understood before commencing care and support services
	4.36	Services are provided by staff that champion dignity (the organisation and employees should adopt the National Dignity Council / Dignity in Care Dignity Do's and respect the service user's right to privacy and their relationships with other people who live in or visit their home.
Support staff recognise the importance of recording professional accurate and relevant information in the care notes/ care logs and communicating with the office.	4.37	Support staff complete accurate, relevant and legible care logs/notes at the time of occurrence, no records are entered or altered retrospectively; the use of abbreviations, inappropriate personal comments about the service user and slang language is not acceptable. Care notes/ logs contain appropriate information in reporting incidents and action taken There is a robust system in place to audit/monitor the quality of care notes/logs and appropriate action is taken in respect of poorly completed records.
Consistent services are provided by support staff known to the service users/ family/their carer.	4.38	Evidence supports that service users know who their care worker/key worker is, and how they can contact the organisation if they have any concerns, wish to cancel/change the time of a service, or are unhappy with the person(s) scheduled to provide their services. Where they are unhappy with the person(s) scheduled to provide their services, this must be fully investigated and action implemented to ADDRESS THE ISSUES
Support staff are able to establish good working relationships and know and	4.39	Rotas confirm that support staff are scheduled to provide services to the same service user(s), unless they request a change for any reason, (to be recorded in supervision notes). Consistency in staffing promotes good relations and early detection of issues in respect of health and wellbeing.

understand the needs and individuality of their service users, and will be able to identify and observe changes in the service user's health and wellbeing as they occur.		
Service users' personal preferences in respect of how they receive their services and the gender of the support staff scheduled to provide their personal care services, must be respected at all times	4.40	Rotas confirm that the correct gender(s) of the support staff is scheduled to provide services, in line with the service user's cultural, religious requirements and personal preferences.
Care and support planning takes account of the wider needs of the service users (beyond those being met directly by the service) which impact upon their need for support, and the extent to which these are currently being met by external agencies.	4.41	Service user file notes or care and support plans demonstrate such planning takes place.
Outcomes of reviews (of individual care needs) are used to inform service development and strategic planning.	4.42	Reviews of care needs consider how successful the service has been in assisting service users in realising their plans, targets or aspirations and this information is used to improve services through a continuous improvement programme.
Formal mechanisms are in place between the service and external agencies to facilitate and enable joint working	4.43	Initiatives such as joint care planning arrangements and/or joint training can be described by staff and evidenced by appropriate documentation.
There are periodic meetings with key agencies to plan or review care service delivery.	4.44	Both the organisation and the other professional services are able to provide records of such care planning meetings and reviews.

Standard 5: Security, Health and Safety		
Service users, together with those who work in or visit the premises, are in safe and accessible surroundings that promote and protect their wellbeing; and the security and health and safety of all individual service users and staff are protected at all times.		
Objectives		**Sources of Evidence**
Successful health & safety management requires an effective policy and organisational procedures to be in place which are accessible to all employees and service users. All health and safety arrangements **must** be continually measured, monitored and revised, where necessary. An annual plan to ensure that health and safety standards are adequately reviewed by the qualified responsible person must be in place.	5.1	The organisation will appoint a responsible person/consultant with the necessary skills, knowledge and experience to give guidance, advice and to ensure the organisation complies with their duty as an employer in respect of the health and safety at work legislation and to ensure that a high standard in good practice is implemented to protect the health, safety and wellbeing of both service users and all employees. The organisation can produce documented evidence that the person(s) responsible for health and safety is aware of this (included in job description) and is suitably qualified and experienced to do so. An annual plan, together with a risk register, is in place and is reviewed by senior personnel in line with changes in legislation, reported incidents of failings in good practice in respect of health and safety, which includes but is not limited to: poor medication management, moving and handling, infection control and safeguarding incidents that have caused harm to a service user. Accidents at work involving staff and service users **must** be reported to the appropriate authority. Any breeches in security to a services user's home should be reviewed by senior personnel as soon as they occur. Risk controls should consider assessed risks to employees, customers, and any other people who could be affected by their activities As part of the annual plan these should be reviewed at a frequency governed by the nature and level of risk and should identify how it is being managed. Regulations require persons who have a duty to ensure health and safety, to 'manage risks' by eliminating health and safety risks so far as is reasonably practicable, and if it is not reasonably practicable to do so, to minimise those risks so far as is reasonably practicable. There is an operational lesson learned process in place, which ensures a debriefing in respect of all reported incidents/failings, is conducted and includes all persons involved, and any required changes, training needs and improvements are implemented.

There is a comprehensive up-to-date Health and Safety policy which has been signed and dated by the personnel responsible for health and safety for the organisation.	5.2	The policy is less than three years old and is in accordance with relevant legislation. It includes where applicable: • Health and Safety at Work Act 1974 (HASAWA) • Manual Handling Operations Regulations 1992 (amended 2002) • Control of Substances Hazardous to Health 2002 (COSHH) • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) • Disability Discrimination Act 1995 and the Equality Act 2010 • Health and Safety (First Aid) Regulations 1981 • Gas Safety (Installation and Use) Regulations 1998 • Electrical Equipment (Safety) Regulations 1994 • Plugs and Sockets etc. (Safety) Regulations 1994 • Working Hours (Working Time Regulations) • Safe procedures and the use of PPE • Fire safety and precautions in a service users home • The disposal of clinical waste All staff are regularly consulted on the policy and its contents to ensure they are kept informed, up to date and have contributed to not only their own safety but the safety of the service users and others. Reported health and safety incidents are discussed in staff meetings and supervision sessions as appropriate. Health and safety risks for service users are discussed, managed and reviewed with the service user / family/ advocate (where necessary) / their carer in line with the good practice procedures operated by the organisation and are covered under Standard 3 Personal Support Needs and Risk Assessment.
The organisation must ensure that policies and procedures are in place to protect service users and support staff while support activities are being carried out. Support staff have read and understood the policy and are confident in carrying out their duties.	5.3	Staff induction programmes cover the health and safety policy, procedures, and individual files are available for inspection. The induction programme must cover, but not exclusively, the following training: • Manual Handling • Infection Control • Fire Procedures • First Aid • Basic Hygiene • Hand Hygiene • Food Preparation, storage and hygiene • Dealing with emergency situations • The use of protective clothing/equipment

		• Lone Working/Risk Assessments associated with Lone Working • Medication Management Support staff files evidence that the organisation provides health and safety training and annual refresher training for high risk activities, for example, moving and handling, as well as training and appropriate support and guidance on medication awareness/management, infection control, food safety and when and how to use personal and protective equipment (PPE). There is published guidance in the staff handbook, and evidence from supervisions, team meetings and through observational supervisions conducted in the home. Staff supporting and caring for service users that have been diagnosed with organic or functional mental health illness receive training prior to the commencement of the service and are supported by refresher briefings/training as changes in the service use's health and wellbeing occur. The organisation carries out suitable occupational risk assessments that take account of the real and significant risks faced by support staff and good guidance is provided in the care and support plan on how to manage/reduce the risk and protect the service user(s) from harm, e.g. correct methods for moving and handling, use of equipment and or if a new way/ method of working or supporting a service user has been introduced through good practice guidance.
There is a lone working policy designed to alert all staff working alone to risks presented by working alone, to identify the responsibilities each staff member has in this situation, and to describe procedures to minimise such risk. It has been designed to give staff a framework for managing potential and known risk and is accessible to all staff, in an easy to read and follow format.	5.4	Where the conditions of service delivery or its associated tasks require staff to work alone, both the individual staff member and the organisation have a duty to assess and reduce the risks which lone working presents. This policy should be read in conjunction with the health & safety and safeguarding policies, including the West Yorkshire multi-agency safeguarding adults' policy. This policy applies to all staff who may be working alone, at any time, in any situation. Staff should take all reasonable precautions to ensure their own safety, as they would in any other circumstances. Where appropriate the organisation provides a mobile phone, especially in an assessed high risk working environment/situation for the lone worker. Volunteers would not normally be expected to work alone and so should be outside the scope of this policy. Where staff work alone for extended periods and/or on a regular basis, managers/supervisors/care coordinators have made provision for regular contact, both to monitor the situation and to counter the effects of working in isolation Evidence on files both electronic and/or hardcopy confirm this is standard practice and is monitored by the manager. There is a 'no response' procedure in place that is actioned as a priority when support staff are non-contactable or have failed to attend a service user's home at the appointed time.

There are procedures in place to ensure the security of a service user's home and the safety and protection of the service user at all times when providing personal care; including preventing, where necessary detecting and controlling the spread of infectious deceases.	5.5	All staff understand and follow the procedures.
	5.6	All staff carry/wear identification cards at all times when visiting service user's homes and service users are made aware of this protocol verbally when assessing the risk to the service user(s) and it is noted in the service user's handbook. Service users are reminded of this security procedure periodically to ensure their safety against bogus callers. Spot checks are carried out regularly to ensure compliance with this practice, and service users can confirm compliance through a quality assurance feedback process.
	5.7	Support staff wear the appropriate protective clothing, gloves and aprons when providing personal care services. Spot checks are carried out regularly to ensure compliance with this practice and service users can confirm compliance through a quality assurance feedback process.
	5.8	Spot checks by the service provider carried out can confirm that support staff implement good hand hygiene at all times, and support staff comply with good practice in hand hygiene as follows: • Before preparing, handling or eating food • After visiting the toilet, supporting a service user to use the toilet facilities available • Whenever hands are visibly dirty • Before and after emptying urine drainage bags • Before and after wearing sterile/non sterile gloves • Before and after handling urethral catheters, intravenous lines and wound care • Before commencing work and after leaving a work area • After handling contaminated laundry and waste and equipment The service provider views lapses in good hand hygiene as serious, and will take appropriate action against the individual staff member and will increase their performance monitoring process accordingly. Service users can confirm staff compliance with good hand hygiene through a quality assurance feedback process.
The organisation must ensure that all equipment used to support the service user, and assist in the delivery of personal care, is well maintained, clean, stored securely, and suitable for the intended purpose.	5.9	Training records held on file confirm support staff have received appropriate training on all equipment/aids used in the service user's home. Service user's risk assessment documents confirm that the environment/space in the home is safe to operate the equipment, and there is easy access to the equipment wherever it is stored in the home for the support staff. The service user's dignity and right to privacy will be respected at all time. Records confirm hoisting and manual handling equipment is used in accordance with the manufacturer's instructions, is regularly inspected by qualified operatives and is safe to use. Staff know the reporting process for defects in equipment and evidence held on file confirms all reported defects in equipment are actioned and given the priority it requires.

Appropriate action is taken in response to individual concerns raised by the service users or support staff regarding non-compliance of health and safety procedures and/or breaches in security and serious incidents.	5.10	Records of concerns raised, action taken and feedback provided.
	5.11	There is a procedure in place to ensure a responsible person is on call and contactable at all times when staff are on duty (including office hours and out of office hours).
	5.12	Staff can confirm that they are able to contact a responsible person in the event of an incident /unable to gain access to a service users home / to ask for advice or guidance when necessary, or in the event of any situation that prevents them carrying out their duties. Staff can confirm that they are aware that they have an obligation to report death or serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses) to the Health and Safety Executive (HSE) and are fully compliant with and understand how to use HSE RIDDOR - Reporting of Injuries, Disease and Dangerous Occurrence Regulations.
Service users / family / advocates / their carer have been informed and are aware of the health, safety and security policies and procedures and understand how and who to report concerns to.	5.13	Guidance on health and safety regulations and good practice in home care services is provided in plain easy to follow language in service user handbooks, welcome packs or other service user's guide information.
There is a medication policy in accordance with the guidance laid down in national standards, which outlines the roles, responsibilities and procedures for supporting and assisting service users with prescribed medication. The policy has been reviewed annually and is signed and dated. This document should be readily available to all staff and should be complied with at all times.	5.14	The policy is less than three years old and is linked to Leeds multi-agency policy on assistance with medication in a domiciliary setting, or any other subsequent guidance provided by the Council.
	5.15	Staff understand and follow the procedure.
	5.16	The organisation's own records in respect of medication are clear and correctly completed at all times and there is a robust system for checking in place. Where a community pharmacy medication administration record (MAR) chart is supplied, it must be completed correctly and the codes listed below must be used when medicine is omitted by the support staff (reference: Pharmacy First Medication Administration Record Scheme). The coded reasons for omitted medicines: • Patient away from ward/home • Patient could not take dose • Patient refused • Dose not available • Omitted at nurse's/carer's discretion • Doctor requested omission • Un-witnessed self-administration

		• Administered late Any alterations to pharmacy MAR charts can only be made by a qualified health professional and should be dated and signed. Errors must not be obliterated by tippex or biro. Any errors made when signing the MAR chart should be crossed through with an X and details recorded on the organisation's medicines administration record. A record of the printed names, signatures and initials of all support workers must be kept on staff files.
The organisation has clear written procedures in place on medication and any other health related activities within support staff competences that protect service users and support staff and a robust audit process is in place to ensure compliance with the procedures.	5.17	The organisation ensures that staff are skilled and trained to deliver medication services in a way that enables self-determination and independence; care and support plans evidence that the administration/support of medication is delivered in a way that respects the dignity, privacy, cultural and religious beliefs of the service user. Support staff will only provide help with taking medication, or administer medication, with the informed consent of the service user or their family relative/their carer/advocate who may give consent on the service user's behalf and is clearly requested on the care and support plan and the service user's ISA produced by ASC. The support staff must never force a service user to take medication. If a service user refuses the medication then the support staff **must** make a note on the MAR chart/medication administration records; and report it to the office for further guidance and support. Office staff must take their guidance from the community pharmacy in respect of the service user's health and wellbeing. Procedures in relation to medication are covered under the employer's insurance policy.
Any concerns about the health of the service user or the ability of the service user to maintain responsibility for his/her own medication must be reported to ASC.	5.18	Care notes/logs confirm that support staff continually assess whether service users are still capable of managing their own medicines. Office records confirm that concerns are reported and the service user's risk assessment with permission from the service user/family/their carer/advocacy in relation to medication management has been reviewed and a request for a review to be carried out by ASC has been carried out and the care and support plan has been revised accordingly.
It is acknowledged that care workers are not health professionals and therefore **must** receive appropriate training and formal assessment of their competency undertaken in order to enable them to become competent in the prompting/assisting	5.19	Staff induction covers the medication policy and individual files are available for inspection.
	5.20	The appropriate level in medication management training is delivered to all relevant staff, and staff files are available for inspection. Training is refreshed in line with best practice and the competency level required, supporting the service user's personal and individual medication/health related tasks requirements. Spot checks and observational supervisions confirm good practice in medication management. Reported concerns in respect of support staff involving medication management are fully investigated and actioned

administration of medication to meet national minimum standards requirements and comply with best practice.		Lesson learnt in respect of medication mismanagement will form a part of the organisation's operations debriefing practice within the health and safety annual plan.
Staff assessing and managing service users' risk, and support staff, should be trained and skilled to increase awareness, knowledge and implementation of best practice in pressure ulcer prevention and management techniques.	5.21	Training records confirm that support staff are skilled, knowledgeable and understand healthy skin and pressure areas, the causes of pressure sores and those at risk.
	5.22	Staff trained to undertake risk assessments and reviews are skilled and experienced in understanding skin integrity, and are able to recognise all stages of pressure sores and are able to provide practice guidance in moving and handling within the care and support plan for support staff.
	5.23	Support staff must keep good records in skin observations and report any changes and concerns to the district nurse team responsible for supporting the service user.
	5.24	Where a concern is established and skin should be monitored, an identified detailed body map should be provided to give guidance to support staff. Inappropriate moving and handling may result in tissue damage; it is important that support staff are prevented from providing services that require moving and handling, when refresher training is required to be updated.
	5.25	Where the support staff are managing incontinence, service user using pads should be closely monitored for changes in the skin due to the continuous use of pads.
	5.26	Support staff are made aware that sharp objects (rings/watches) may cause damage to a service user's skin when assisting and supporting with personal care and either the sharp object is removed or care is taken. Should any incident where the skin is damaged occur it must be reported to the office, and appropriate correct medical professional/distrust nurse team and monitored by the support staff.
	5.27	The organisation's records held on file confirm details of any other professionals supporting the service user and, when possible, have engaged in joint training and service reviews. Other professionals/district nurse team have been given the opportunity to feed back on the organisation's performance and training on pressure care management.

Support staff rotas/planned schedules are manageable and promote good practice in safe working and quality in service delivery.	5.28	Rotas are planned with enough travel time included to enable support staff to carry out full service activities/tasks required at each visit as per the service user's care plan.
	5.29	Office staff understand that planning manageable runs will be reflected in the morale of support staff and the quality of services received by service users.
	5.30	Office staff are adequately trained in rota planning.
	5.31	Rotas and any changes are communicated effectively to support staff; these communication methods are tested periodically and signed off by a senior responsible person.
	5.32	There is a procedure for dealing with and investigating missed and late calls and the organisation can evidence the procedure is followed, including follow up action, disciplinary is implemented if appropriate, and lessons learned.
There are appropriate arrangements to enable service users to access help in a crisis and emergency. Service users understand the emergency call-out procedures.	5.33	Emergency call out – out of hours contact arrangements are documented and publicised to service users in ways appropriate to their personal needs.
	5.34	Procedures to be available in service user handbook.
	5.35	Service users and staff can correctly describe the arrangements.
Changes in the contents of the health and safety policy when legislative or regulatory changes occur are communicated effectively to both staff and service users.	5.36	The review and amendments are documented and available for audit.
	5.37	Staff and service users are made aware of any amendments to the policy.
A formal methodology exists for conducting health and safety risk assessments.	5.38	The methodology is documented and covers all potential risks (other than risks to individual service users).
Annual reviews of health and safety assessments and compliance with current legislation contributes to service development and strategic planning.	5.39	Annual audits and reviews of compliance with health and safety requirements, training and good practice is used to improve services through a continuous improvement programme.
Service users and staff are involved in the review of health, safety and securities policies and procedures.	5.40	Minutes or other records of the review processes demonstrate participation or at least that all reasonable efforts have been made to secure participation.

Standard 6: Safeguarding and Protection from Abuse and Harassment		
Abuse is any act or failure to act, which results in a significant breach of a vulnerable person's human rights, civil liberties, bodily integrity, dignity or general well-being, whether intended or inadvertent, including sexual relationships or financial transactions to which a person has not or cannot validly consent or which are deliberately exploitative. The risk of being abused depends upon the situation, the environment and those who cause harm, not on the behaviour of victims. Many incidents of abuse are criminal offences. All individuals have the right to live their lives free from coercion, intimidation, oppression and physical, sexual, emotional or mental harm.		
Objectives		**Sources of Evidence**
There is an up-to-date policy signed and dated. The policy clearly outlines the duty and responsibility of staff, volunteers and (where applicable, trustees) working on behalf of the organisation in relation to safeguarding vulnerable adults.	6.1	Under this policy adults at risk are those: • Aged 18 years or over; and • Who may be in need of community home care services by reason of mental or other disability, age or illness; and • Who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. The policy document makes reference to current legislation that supports and protects adults at risk, and is reviewed in line with changes in legislation and good practice in protecting and safeguarding services users, and actively promotes the empowerment and well-being of adults at risk through the services provided. The policy document has been developed to ensure all current regulations are followed when assessing an individual's capacity to make particular decisions, and that decisions made on their behalf are in their best interests if they are assessed as lacking capacity to do this for themselves, and it contains information that complies with the following : • Care Act 2014 • Equality Act 2010 • Mental Health Act 2007 • Mental Capacity Act 2005 - Deprivation of Liberty Safeguards and Code of Practice • Protection from Harassment Act 1997 • Police Liaison Officer (PLO) • Human Rights Act 1998

		The policy will be made freely available to users of the services, their families/their carers/advocates, and to all staff and other professionals providing services for adults at risk. An easy to follow in simple language guide on the policy will be publicised in the service user and staff handbooks. The policy document is reviewed in line with changes in legislation, and recommendations of best practice in safeguarding and protecting adults at risk; the review process ensures the policy is updated in accordance with new directives and changes introduced in to the West Yorkshire multi-agency safeguarding adults policy. The policy is dated and signed by the senior person responsible for carrying out the review process, and disseminating the revised document to all staff (annually). The policy must include an outline of the training that will be available to enable staff to be aware of abuse and how to prevent it; a statement on safer recruitment practices, an outline of disciplinary procedures in the event of abuse being perpetrated by a member of staff and when a referral to the Disclosure and Barring Service should be made (where applicable).
There are robust and up to date procedures for preventing and responding to (all kinds of) actual or suspected abuse or neglect. The procedures will be in accordance with the Care Act and the Leeds Safeguarding Adults Partnership Board - West Yorkshire multi-agency safeguarding adults policy.	6.2	The procedures comply with good practice, are documented and address all forms of abuse which include the following : • **Discriminatory abuse,** including that based on a person's ethnic origin, religion, language, age, sexuality, gender, disability, and other forms of harassment, slurs or similar treatment • **Sexual abuse,** including rape and sexual assault, contact or non-contact sexual acts to which the adult at risk has not consented, or could not consent or was pressurised into consenting • **Psychological abuse,** including emotional abuse, threats of harm or abandonment, deprivation of contact or communication, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks • **Financial or material abuse,** including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits • **Neglect or acts of omission,** including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; failure to report abuse or risk of abuse • **Physical abuse,** including hitting, slapping, pushing, kicking, misuse of medication, inappropriate restraint, or inappropriate sanctions • **Institutional abuse,** indicated by repeated instances of unsatisfactory professional practice, pervasive ill treatment or gross misconduct indicating an abusive climate Other forms of abuse, (for example, domestic violence or child protection), may highlight an increased risk that adult abuse could be taking place. Self-harm or self-neglect may also be considered an indicator of harmful actions by someone other than the individual at risk.

	6.3	The procedures are in accordance with the Public Interest Disclosure Act 1998, and where appropriate the Care Act 2014, and uphold the service users' human rights under the Human Rights 1998.
	6.4	Procedures promote an open organisational culture which encourages and appropriately supports staff. Staff are able to describe the principal elements of the procedures, the reasons behind them, and their implications for their work. They will know to whom they should report any actual or suspected abuse or neglect, and are able to describe the policies concerning professional boundaries in respect of staff-user relationships.
	6.5	Safeguarding procedures include a clear whistle-blowing procedure, including provision for contacting an external agency (including protection for 'whistle-blowers' from being victimised or unfairly treated). The procedures will be in accordance with the Public Interest Disclosure Act 1998 and with the Department of Health guidance "No Secrets" to be superseded by the Care Act. Staff are informed and understand that all employees are protected against dismissal and other adverse action if they make complaints or public disclosures about malpractice. In accordance with the Mental Capacity Act 2005 adults at risk will be given information to support them in speaking out and protect themselves from abuse knowing they will be listened to and believed.
	6.6	The procedures give the service users the right to have their privacy respected which includes the right to have information kept confidential, unless an interference with that right can be justified and if, in the particular/individual safeguarding case, it can be evidenced that the need for protection outweighs the right of confidentiality.
	6.7	The procedures give clear guidance on the action to be taken if abuse is witnessed or suspected; an outline of disciplinary procedures in the event of abuse being perpetrated by a member of staff; and guidance on when a referral to the Disclosure and Barring Service should be made (where applicable).
	6.8	Staff responsibilities in relation to the safeguarding of adults at risk must be clearly documented and incorporated into all individual terms and conditions and specified contracts of employment.
	6.9	All safeguarding procedures have been reviewed in line with changes in legislation or, as a minimal, annually and staff are made aware of any changes and amendments to procedural documents and guides in best practice.
All staff have been DBS (Disclosure **and Barring Service**) checked and appropriate action taken if returned positive before commencing unsupervised employment.	6.10	Details of DBS checks are recorded in staff files and available for inspection. DBS applications have been processed and evidence is kept on staff files in relation to the reference number. DBS are reviewed for existing staff every three years or in line with current compliance regulations.
	6.11	Staff records evidence job shadowing on all care visits for new staff including shadowing on personal care. Support staff competencies to confirm the appropriate skills and knowledge and confidence to work alone are signed off by a supervising officer at the end of a period of job shadowing.
	6.12	There are robust risk assessments (and, where applicable, risk management plans) in place for staff that have a positive DBS returned.
Two appropriate references are obtained and validated before staff commence employment and any relevant checks have taken place.	6.13	Two references from employers (or where no employer references are available from professionals) are recorded and available in staff files for inspection.
	6.14	The recruitment process looks at reasons for any gaps in employment

All support staff have a **duty to report any** allegations or suspicions of abuse of an adult(s) at risk. This places an individual responsibility on staff to report and an organisational responsibility to ensure that staff receive support and training in safeguarding adults.	6.15	All staff must complete a comprehensive induction before working with service users. The induction must include the following areas :- • Employer policies and procedures • Contract of Employment • Equal Opportunities • Health and Safety • Protection of Vulnerable Adults • Risk Assessment and Management Logs of staff induction/training records are available for inspection. Induction records are signed and dated by both employer and employee.
	6.16	Safeguarding training sets out clear expectations of staff (or volunteers) behaviour, manner and attitude in the provision of services and there is documentary evidence that induction, training, supervision etc. specifically addresses issues of professional boundaries in respect of staff-user relationships and this is reviewed and revisited with staff on a regular basis.
	6.17	An organisational staff code of conduct or an adopted equivalent good working practice is publicised in the staff handbook.
	6.18	The organisation ensures that appropriate guidance and training about safeguarding adults from abuse is accessible to staff, put into practice, implemented and monitored. Staff can explain how to recognise symptoms of abuse or neglect, and can explain how to deal appropriately with inappropriate behaviour/aggression from service users.
	6.19	There are appropriate procedures, training and arrangements in place to maintain a clean environment and effective infection control to protect the service user(s).
	6.20	Appropriate support is provided to service users and/or staff (including staff who have raised safeguarding concerns and staff who are alleged perpetrators of abuse).
	6.21	Staff are appropriately supported through supervision in dealing with a reported abuse case.
	6.22	Appropriate action is taken where an allegation of abuse involves a member(s) of staff and where it is fully substantiated, following an investigation, is reported to DBS.
Staff responsible for reporting /alerting and completing safeguarding reports **must receive** safeguarding training either Leeds City Council training or equivalent.	6.23	Senior staff who are responsible for investigating allegations, collating evidence, undertaking interviews and completing reports in compliance with the West Yorkshire Multi-Agency Safeguarding Adults Policy have staff records that evidence they are skilled and qualified to do so, and have attended refresher training to be kept informed and updated in respect of best practice and changes in safeguarding legislation/guidance.

There is a documented risk assessment addressing the potential for staff to benefit personally when working with vulnerable people (including but not limited to handling service users' money, provision of financial advice, power of attorney, wills and bequests) - and procedures in place to minimise the identified risks.	6.24	Service user information and staff procedures publicised in handbooks /guides inform service users of the procedures that prevent staff from personal benefit when working with vulnerable people.
	6.25	Where support staff are dealing with money directly with a service user they should record details of all transactions in a cash record/duplicate book and sign and date the record. Financial records should be audited for compliance every six weeks. Service users are informed that support staff will not make a financial transaction that is not set out in the service user's care and support plan.
	6.26	Care and support plans, reviews/office records evidence support staff have informed the office staff of any change or concerns regarding the service user's financial circumstances, a review has been conducted in line with protecting the service user as appropriate to the identified concern.
Prompt action is taken in response to individual safeguarding reports/ allegations or concerns from staff or service users.	6.27	The organisation ensures service users/families/their carers/advocates understand what constitutes abuse and know to whom they shall report any actual or suspected abuse or neglect.
	6.28	Staff know to whom they should report any actual or suspected abuse or neglect.
	6.29	The existence of the procedure is publicised in appropriate ways e.g. service user induction or welcome packs or handbooks, on staff notice boards etc.
	6.30	A log/record is maintained of all reported and potential allegations of abuse/safeguarding, and evidences the action implemented, the outcomes of investigations carried out and any improvements implemented.
	6.31	Where a decision has been made to make a safeguarding alert this has been discussed with, and explained to, the service user/family/their carers. This will include the process, what they can expect to happen, and how they will be supported, who they can contact etc.

There is a co-ordinated multi agency approach to tackling abuse or neglect.	6.32	Notes of multi-agency working e.g. minutes and agendas, named contacts, joint action plans etc.
There is a periodic (at least annual) review of the effectiveness of abuse policies.	6.33	The review should take into account all safeguarding alerts and investigations, including those reported by the organisation to ASC Contact Centre/Safeguarding on behalf of their service users and their concerns about a third party involved with the service user. If the organisation does not receive a response from the appropriate safeguarding coordinator what action was taken? What was the time delay? What did they do to escalate this case with Safeguarding? What action have they taken to protect and continue to support the service user? What changes have been implemented or required to improve communication and the reporting process for service users and staff to make this process more expedient?
	6.34	The review is documented and examines how each reported case was dealt with and aims to identify and address any distinctiveness to reporting of actual or suspected abuse or neglect.
Service users/families/their carers/advocacy views and experiences are incorporated in reviewing the policies and procedures.	6.35	Minutes or other records of the review processes demonstrate participation.
Cases of abuse and or neglect are proactively used in planning and shaping services with the involvement of service users and staff.	6.36	Lessons learnt/what could we do better quarterly review of all safeguarding cases is conducted by senior staff and a debriefing process is in place.
	6.37	Annual service reviews document evidence of involvement of service users and staff.
	6.38	Action plans available for inspection detailing targets, outcomes and timescales.

Standard 7: Complaints and Compliments		
Formal and informal complaints should be viewed as an opportunity to learn and improve for the future, as well as a chance to put things right for the person(s) or the establishment that has made the complaint. Good complaints management helps to safeguard against poor practice in service delivery and a poor reputation. It puts in place the mechanisms to create and develop a culture where complaints and reports of service users dissatisfaction are valued and contributes to improving the quality of services provided. Monitoring trends and patterns in complaints and concerns reported, in respect of service delivery, facilitates early detection of systemic problems and poor performance. A complaints handling system must be modelled on principles of fairness, accessibility responsiveness and efficiency, and can demonstrate that the learning process is used beneficially to improve the experience of service users who use the services.		
Objectives		**Sources of Evidence**
There is a written complaints policy that takes account of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, that makes clear: - who to complain to in the first instance - what the organisation will do - timescales - how to escalate a complaint and appeal in the case of dissatisfaction; e.g. contact details of Adult Social Care complaints department and CQC	7.1	The policy is in place and has been signed and dated by the responsible senior personnel/ registered manager overseeing the management of complaints received by the organisation from whatever source. The policy is compliant with the Public Interest Disclosure Act 1998 and the Data Protection 1998 and gives guidance and information on the organisation's complaints management principles and aims in managing the complaints process which should include the following: • To provide a fair customer focused complaints procedure which is clear and easy to use for anyone wishing to make a complaint or express their concern about the services they are receiving • To publicise the existence of the complaints procedure so that people know how to contact the organisation to make a complaint in an easily accessible format for service users/family/their carers/advocates • To make sure all staff know what to do if a complaint is received and how it will be recorded on the organisation's complaints management system, and whose responsibility it is to respond to complaints • To make sure all complaints are acknowledged, investigated fairly, and in a timely way • To make sure that complaints are, wherever possible, resolved satisfactorily, action is taken to prevent complaints recurring, and where necessary relationships are repaired • To gather information which helps the organisation to improve • To comply with the organisation's confidentiality policy and procedures, all complaints information will be handled sensitively, informing only those who need to know and following any relevant data protection requirements • To ensure consent and confidentially is not compromised at any time during the complaints process • To be open, honest and transparent in dealing with and responding to complaints and investigation outcomes

		The policy document gives guidance on the options available to a person(s) if they are dissatisfied with how their complaint was handled, or with the outcome, and who they can escalate their complaint to, for example: • Leeds City Council complaints department • Care Quality Commission • Local Government Ombudsman For larger national home care providers, unresolved complaints should be escalated internally to the senior management team and if necessary the executive team to respond. Organisations encourage and support their service users to complain/give feedback on the services provided if they are dissatisfied, and should offer the support of independent interpreters, advocacy services as appropriate. The policy should be reviewed in line with changes in complaints guidance and regulations and directives on good practice/or at a minimum of every three years.
The complaints procedure should support a more flexible approach towards handling individual complaints, which focuses on the needs and wishes of the people involved. They should be simplified so that it is much easier for people to share their experiences and for staff to respond. They should make sure that people's experiences help to improve services and they should resolve complaints more effectively by responding personally, positively and promptly.	7.2	A complaints handling system must be properly staffed and resourced. The organisation must have enough skilled and trained staff to enable it to comply with its own timeliness standards for complaints handling. The procedure is written in simple language and is available in formats appropriate to the needs of as many service users as reasonably possible. A senior manager should be responsible for managing the complaints handling system. This person's responsibilities should include the following: • **Promoting a positive culture** - they should be the complaints 'champion', ensuring that the organisation remains focused on having a strong, integrated complaints system • **Integrating complaints information** - Complaints information should be an integral resource for all business analysis and service improvement • **Keeping informed** - The complaints manager must keep up to date with best practice and regularly review the agency's complaints handling system The complaints procedure/process confirms that all staff are made aware that in seeking to resolve a complaint raised at service level, a rapid response and or a personal visit by a senior member of staff often results in effective complaints resolution. The organisation's complaints policy and procedure is included in the induction of their staff.

		The procedure and the timescales for responding to informal and formal complaints, make sure that adequate time is allowed for the investigation, supporting, advising and assisting staff to resolve and put right the issues giving rise to the complaint or dissatisfaction when possible. The procedure makes sure a 'fair and just' organisational culture is maintained and that staff members are informed if a complaint is made against them, that they receive a copy of the complaint, are given a chance to give their side of the story, and are made aware of the process and timescales for responding to complaint The complaints manager considers each complaint openly, honestly and objectively, seeking to understand the scope and nature of the complaint including identification of the main issues and what the person making the complaint is asking for, for example apology, explanation; they ensure that all investigations are conducted in a fair and just manner which is supportive to those involved and discourages the attribution of blame. The complaints procedure evidences how the complainant is supported through every stage of the complaints process. This includes: a meeting with the complainant to better understand their concerns/dissatisfaction, keeping them, or (nominated representative), informed of the investigation, confirming in writing the outcome of the investigation, and offering external support where language, speech, or sensory impairments are a barrier to effectively communicating with the complainant. The organisation implements a quality follow up/feedback process to ensure continued satisfaction. The procedure ensures absolute impartiality; complaints handling staff should not have a defensive approach in responding to complaints about their organisation or its staff. Nor should a complainant be obliged to prove they are right or the organisation/staff member is wrong. An apology does not confirm acceptance of responsibility, it does however, acknowledge and recognise that there is a need to respond to a level of dissatisfaction, and the possibility that something is wrong, and to put it right may require making changes.
All service users/family/their carers/advocates are made aware of the complaints procedure and how to use it.	7.3	The existence of the procedure is publicised in appropriate ways, for example, in service user induction, welcome packs or handbooks. Service users are reminded of the process at service reviews, on web sites, in newsletters, service user's forums, and quality assurance processes. Service users are updated and made aware of any changes to the procedure following service reviews or changes in the organisation's guide to complaints management. Contact details of who to make a complaint to, other than support staff, is updated, and service users are informed of staff changes.
Staff understand and follow the procedure.	7.4	There is evidence that staff follow the procedure and failure to follow it may lead to disciplinary or other appropriate action.

	7.5	All verbal dissatisfaction received at service level direct to staff is reported back to the office and can be evidenced on the service user's file/office records. Reports of dissatisfaction at service reviews or through quality feed-back processes are actioned and the outcome is reported back to the service users(s). In all cases the support/office staff ensures that the service user/family/their carer/advocate is listened to, and assisted to access the complaints process.
Appropriate/timely action is taken in response to individual complaints. Where a complainant /individual does not want to identify themselves, the complaints procedure must still be followed.	7.6	Evidence held on file confirms there is an audit trail, ensuring that records are kept of the complaints investigation. These records are factual, clearly identify the complainant, the reason for the complaint/dissatisfaction, the outcome of the investigation and the changes made/improvements required to increase service user(s) satisfaction. Records are dated and identify staff involved in the investigation.
The language and presentation of the procedure promotes an understanding by all service users, and promotes a commitment to equality and diversity.	7.7	The procedure makes reference to the fact that no individual should receive less favourable treatment or be victimised on the grounds of race, colour, nationality, ethnicity or national origin, sex, gender reassignment, or caring responsibility, sexual orientation, age, physical, sensory or learning disability, mental health religious beliefs, in how a complaint is acknowledged, processed, investigated, responded to; and it receives the priority it deserves. The language used in the procedure and guidance provided is simple, and is in several easy to follow formats and where it is appropriate, translated. A contact number is given to each complainant, preferably with the name of a contact person, in formats as appropriate to the service user and their personal ability. It must be recognised that older service users may have poor literacy skills and staff must be respectful, sensitive and provide information in a format that would suit and aid the service user (s) to be able to make a complaint/raise a concern that suits their own individual skills and ability.
Service users understand the procedure.	7.8	Service users understanding and satisfaction levels of the complaints procedure is tested and necessary amendments made as a result of service user feedback, to both the procedure and publication/sharing of information.
Outcomes of complaints/ reported concerns are fed back to complainants both verbally and in writing.	7.9	Service user's files or other records contain written correspondence or notes of verbal feedback. Where complainants have escalated their complaint externally, because they are dissatisfied with the outcome, evidence supports that the organisation has cooperated with independent reviews/processes.
Training and information on service user feedback including complaints, investigation and management is available for staff at the appropriate level.	7.10	Corporate training programmes/courses, encompassing general awareness training on complaints management, are available for all staff likely to come into contact with service users; as well as specialist complaints management training for investigating officers which should include: interviewing, collecting and analysing evidence, report writing and effective communication.
	7.11	A reference guide has been produced for staff regarding managing complaints and can be found in the staff handbook.

The complaints manager is skilled and experienced in managing complaints.	7.12	Whilst recognising the right of every individual to make a complaint, and to be treated equally in having these thoroughly investigated and fully responded to, there will be times when there is nothing further that can be reasonably done to assist them. Where this is the case, and further communications would place inappropriate demands on staff and resources, consideration may need to be given to classifying the person making the complaint as unreasonable. Evidence must support this decision and that everything possible had been done by the complaints manager to resolve the complainants concerns. Adult Social Care should be informed and a joint protocol to review and appropriately manage the service is agreed and implemented. It is essential that the individual's human rights are not compromised in how the complaint is managed.
	7.13	Service users/family/their carers/advocates feel able to complain and are confident that their complaint will be dealt with in a positive manner.
Staff at all levels communicate effectively with service users and support staff. Responses are made promptly and appropriately to issues and concerns that are raised, service users are given the opportunity to feedback their opinions and experiences of the service To management staff.	7.14	Office staff are trained in customer care and effective communication.
	7.15	Service users confirm there is a good level of customer care when contacting the office.
	7.16	Staff confirm good communication and support from the office. Complaints and their outcomes are discussed as appropriately in supervision sessions and team meetings.
	7.17	There is both a planned and responsive approach to collecting feedback from service users and staff; this feedback is incorporated into improving service delivery.
The complaints procedure is reviewed annually or as and when legislative changes occur.	7.18	Reviews and amendments are documented and available for audit purposes.
	7.19	Staff and service users are made aware of any amendments to the procedure.
Service users and carers are encouraged and empowered to use the complaints procedure.	7.20	Records (for example, case notes, support/ care plans), show that the individual service users have been encouraged and supported in the use of the complaints procedure.
The organisation facilitates opportunities for service users/carers to talk directly to the management about their experiences in receiving services and feedback is used to develop the service.	7.21	Staff at every level recognise how valuable service user involvement is, and are committed to listening to the views, suggestions and concerns of service users. Formal and informal consultation is facilitated through surveys, periodic meetings, or the use of any other media tool, for example, websites and newsletters.
	7.23	Minutes of meetings or other records demonstrate service user participation.
	7.24	Service users/carers can confirm that they are encouraged and supported to participate and are given the opportunity to communicate with senior management staff other than carers, to express their views on the services being delivered.

Complaints are proactively used in planning and shaping services with the involvement of service users and carers.	7.25	There is a periodic (at least annual) review of complaints received, and this is shared with service users and carers who are participating in the review process to determine if any changes or improvements to the service can/should be made.
	7.26	There is evidence of identified learning from complaints received.
Reviews of the complaints procedure involve service users and carers.	7.27	There is a periodic review, (at least every three years), of the complaints procedure that involves service users/ family/their carers /advocates and staff in determining any changes to the procedure.
	7.28	The review should aim to address barriers to the function of the policy, such as whether there is sufficient awareness of the policy and what might inhibit complaints.
All reported formal complaints received by the organisation must be reported to the Care Quality Commission.	7.29	Reports to CQC must contain outcomes of investigations and responses to the complainant, and any other relevant information as requested by CQC.
Verbal or written compliments will be recorded by the member of staff receiving the compliment, and passed to the appropriate manager for recording on the system/ register. Where compliments have been received direct to the office, verbally or in writing, about an individual member of the staff team, they will be informed. Feedback on compliments should be shared with all staff in team meetings and staff supervision sessions.	7.30	All compliments are recorded, acknowledged, and a copy is sent to the relevant supervising officer to provide feedback to the member of staff or service.
	7.31	Compliments are collated, and are provided in the performance work book used to review and appraise the organisation's performance in contract review meetings, and in reports to the governing boards provided by Leeds City Council complaints office.

Standard 8: Equality and Diversity		
An organisation which protects and promotes equality is one in which everyone can flourish. It seeks equality in the valuable things that people can do or be, so that everyone has the real freedom to live in ways that they value. An organisation championing equality and diversity recognises the diverse needs, situations and goals of individuals, removes discrimination and prejudice, and tackles the social and physical barriers that limit what people can do and be. There is a commitment to the values of diversity and inclusion and to the practice of equal opportunity (including accessibility in its widest sense), and the needs of black and minority ethnic service users are appropriately met.		
Objectives		**Sources of Evidence**
There is an up-to-date equal opportunities and diversity policy that will actively encourage diversity to maximise achievement, creativity and good practice, and to bring benefit to individuals and the communities in which the organisation operates. Organisations with less than 50 employees must be able to demonstrate their approach to Diversity	8.1	Equality is about treating all employees, service users/family their carers/advocates fairly and ensuring everyone is given a fair chance in life, in employment opportunities and in training and personal development opportunities. It is common to think equality is about treating everyone the same; but there is a danger that if the organisation treats everyone the same they are not acknowledging their differences and personal needs, which could have an impact on how that person is feeling and how services are delivered. It is therefore essential the policy provides guidance and ensures all staff comply with anti-discrimination legislation, and clearly states disciplinary action, including dismissal, will be taken against any member of staff found responsible for harassment or discrimination. The aims and objectives of the equal opportunities and diversity policy are clearly written in plain, simple and easy to follow language for all staff and service users: • To encourage, promote and celebrate diversity in all our activities and services • To ensure equal access to employment (where appropriate volunteering) opportunities • To ensure equal access to service delivery • To ensure compliance with legislation on discrimination and equality; the Equalities Act 2010, the Human Rights Act 1998 • To create environments free from harassment and discrimination • To maximise the use of resources in the best interests of staff, volunteers and service users • To confront and challenge discrimination where and whenever it arises, whether it is between colleagues or in all areas in which the organisation operates and comes into contact through service delivery • acceptance and implementation of this policy is a necessary requirement of any position of employment in the organisation • To ensure, through positive action and so far as is practicable, the organisation's office premises and home care services are accessible to all people

		• To ensure that employment and advancement within the organisation is determined by objective criteria and personal merit An effective equality policy fosters a culture of co-operation and mutual respect between workers. The organisation recognises the need for a continuing commitment to genuine equal opportunities and diversity within the organisation and the effectiveness of the policy's aims and objectives can only be judged by how the policy operates in practice. Responsibility for implementing and developing the policy rests with the responsible senior personnel /registered manager. Staff handbooks evidence the organisation believes that all staff have an individual responsibility to accept the policy and ensure a personal involvement in its application. The aims and objectives will be achieved through action planning, effective monitoring and a willingness to tackle problems where they arise. Where evidence is found of ineffectiveness, immediate remedial action will be taken The policy is reviewed every three years, or as and when legislative or regulatory changes occur.
There are written procedures covering equal opportunity anti-discriminatory practice and harassment that cover employment and service delivery.	8.2	The organisation's procedures aim to evidence the organisation as a positive equal opportunities employer and provider of services, and can evidence that no job applicant, employee, volunteer, trustee, member or service user/family/ their carer/advocate will receive less favourable treatment on the grounds of race, colour, nationality, ethnic or national origin; sex; marital status or caring responsibility; sexual orientation; age; physical, sensory or learning disability; mental health; political or religious beliefs; class; HIV status; employment status; unrelated criminal convictions; union activities. Nor will such person be disadvantaged by conditions or requirements which cannot be shown to be justifiable. This principle applies to recruitment, promotion, training, benefits, facilities, procedures and all terms and conditions of employment.
	8.3.	The procedures cover all staff and access to employment.
	8.4	The procedures cover service users and access to holistic services. In taking a holistic approach to providing care and support services, the organisation respects and considers all of a service user's needs (physical, intellectual, emotional, social, cultural and spiritual),providing opportunities for these needs to be met, and to improve a service user's quality of life.

	8.5	The procedures give staff guidance on the organisation's ethical principles for appropriate behaviour, focusing on actions, attitudes and values. Staff must always behave in an anti-discriminatory and anti-biased way. The procedures cover the inappropriate use of benevolent oppression in supporting service users, whereby well-meaning support staff make decisions on behalf of the individuals in their care, or prevent them from behaving in an apparently risky way, in the interests of their safety.
	8.6	The procedures confirm how service users will be consulted with regards to service provision. Services will be monitored through annual service user evaluations to determine the effectiveness of its services for addressing the needs of its diverse service users, and they inform the review of policies, procedures and practices that impact on equal opportunities and diversity practice, which includes safeguarding, health and safety and complaints, risk management and support planning.
	8.7	The procedures evidence that the organisation strives to ensure staff (and, where applicable, volunteers) and service users reflect the wider communities in which they operate. The collection/analysis of data is vital in informing change and improving performance. Statistics of services and the users will be collected and analysed in relation to equality and diversity matters.
	8.8	Service users are made aware of their responsibilities to comply with the equality and diversity policy and procedures in their relations with all staff visiting their home, and/or delivering services.
There is a recruitment and selection policy that aims to eliminate discrimination in recruitment processes. It ensures best practice in employee's equality and human rights, working conditions, dignity at work, employee welfare and fair and transparent recruitment practices.	8.9	Clear and accurate information on vacant posts should be available through advertisements, job descriptions, person specifications and interviews. Vacancies should be advertised sufficiently to reach the widest possible range of candidates, either internal and/or external.
	8.10	All recruitment material should not imply any preferred group, unless a genuine occupational qualification exists limiting a post to a particular group.
	8.11	Person specifications may include 'essential' and 'desirable' requirements that are necessary and justifiable. Care, and advice where necessary, should be taken to ensure these are not discriminatory.
	8.12	All applicants will be informed, through all recruitment material, of the organisation's commitment to equalities and diversity and the existence of this policy.
	8.13	The short listing process for interview will not select candidates on the basis of the ethnicity, gender, name, possible disability or age of the candidate unless applying positive discrimination. The interview panel or person must take extreme care not to ask discriminatory questions unrelated to the requirements of the job, e.g. race, colour, nationality, ethnic or national origin; sex; marital status or caring responsibility; sexual orientation; age; physical, sensory or learning disability; mental health; political or religious beliefs; HIV status; employment status; unrelated criminal convictions; union activities.
	8.14	Documented evidence of monitoring of equal opportunities of all applicants, and proper records of employment decisions are maintained, and regular reviews of employment practices are carried out.
	8.15	The organisation monitors the composition of its workforce and service user base and introduces positive action if it appears that their policy and procedures are not fully effective.

The organisation values a diverse service user(s) foundation and the individuality and creativity that every worker potentially brings to the workforce. Equality and diversity is about good employment practice and makes sound business sense.	8.16	The organisation **must** inform Leeds City Council if any proceedings have been brought against the organisation in respect of Employment Tribunals, Employment Appeals Tribunals, or any other court or tribunals, and whether they have made any findings of unlawful discrimination against the organisation.
All staff are familiar with the above procedures and by putting the organisation's values, equality and diversity principles in to practice, it creates an environment where everyone is treated with dignity and respect, where the talents and skills of different groups are valued, and where productivity and customer service improves because the workforce is happier, more motivated and more aware of the benefits that inclusion can bring.	8.17	The equality and diversity policy and procedures are covered in induction programmes, to ensure that the highest standards of equality and diversity practice are observed in the delivery of services, and cultural awareness and knowledge is strengthened.
	8.18	The organisation's annual training plan, and personal development opportunities, evidence that appropriate training on equality, diversity and human rights is provided to enable all staff (and where appropriate, volunteers), to reach their potential, and to perform their jobs effectively with confidence. The training offered will take into account the needs of staff and service users to ensure that competence is maintained.
	8.19	The responsible manager/registered manager, and staff involved in recruitment and selection, have undergone equality and diversity training. Evidence of training is available for inspection. Training must include an awareness of providing personal care for people with a range of needs
	8.20	Employment records evidence that the organisation offers mentoring opportunities to existing and new staff, and offers to conduct exit interviews that contribute to a review of the organisation's aim to create a working culture of inclusion, respect and support for all staff.
	8.21	The equality and diversity policy is clearly written in simple, plain language in the staff handbook, with guidance for staff involved in person-centred planning and service delivery, on cultural and diversity requirements and religious information.
	8.22	Supervision notes evidence that there is regular contact with staff and that this contact takes place within a context of dignity and respect, and that the values of inclusion are integrated into how staff are supported and when organising staff work and as part of performance management.

A holistic approach is vital in planning and delivering personal care and support in a way which takes seriously the values and beliefs that are central to the life and well-being of service users. The cultural and religious beliefs of the service user(s) are respected and the communication and dietary needs are catered for.	8.23	Where necessary, service users are able to communicate in their first/preferred language, and are confident to complain without feeling victimised.
	8.24	There is evidence that reasonable efforts have been made to provide written communications (including information about the service and how to apply) in the preferred forms (e.g. other languages, signing, Braille etc.) for as many service users or potential service users as feasibly possible.
	8.25	Services where meals are provided cater for varying dietary requirements. Support staff preparing and cooking meals are aware of religious and cultural requirements in food preparation. Support staff providing shopping services are made aware of cultural and religious requirements and shop accordingly
	8.26	Staff responsible for scheduling support staff are aware that many cultures have strong 'modesty codes', which will make certain types of physical, contact inappropriate, and will make the presence or assistance of staff of the opposite sex unwelcome. Where the organisation has been informed that male support staff are not permitted to provide personal care for a female or to be alone with a female in her home, a service user's gender preferences in who delivers their services are clearly recorded on all their records held on file and in the home and this is respected at all times but especially at peak periods such as staff holidays or staff sickness cover.
	8.27	Care and support plans evidence that festivals and religious holidays are observed and respected by staff providing services, and guidance has been given to support staff to enable them to support service users to observe their customs and traditions in cultural and religious beliefs.
Staff understand and are sensitive to particular needs of service users from minority groups.	8.28	Records show that staff are specifically recruited or trained to ensure understanding, and where possible their ethnicity matches the services users they have been scheduled to provide a service for; or where it is possible, that they have the ability to speak the service user's first language, and/or have the same religious observations. It must not be assumed that the staff member needs to have the same country of origin to do so. It must not be presumed that because a service user speaks a community language they can also read it.
	8.29	Senior staff know how to access and use translation/interpretation services effectively, and are skilled and trained to work with service user's with hearing and sight impairments, and to work collaboratively with support networks to ensure best practice is implemented in communicating and providing services in a way that suites the individual service user.
	8.30	The use of a person's name is very strong in many cultures and great care should be taken by all staff in how they address and use a service user's name; records evidence that staff are skilled and trained to understand the cultural importance of the service users first and last name and not to make assumptions.
	8.31	Staff are aware of the challenges service users with a learning disability may face, and are skilled and competent to support both the service user and, where appropriate, their family member/their carer. Minutes of meetings confirm the organisation, working collaboratively with the social worker and the service user's other support networks, ensures best practice has been implemented when communicating with and supporting the service user.

The equal opportunities policy is reviewed annually or as and when legislative or regulatory changes occur for effectiveness and compliance at all levels throughout the organisation.	8.32	The review and any amendments to the policies are documented and available for audit. The review process and any subsequent changes or improvements made to the document as a result of the review, will be monitored at senior service level and will include the regular involvement of service users and all staff,
The organisation has its own equalities strategy to meet the changing demographics of the Leeds population and to deliver services to diverse communities.	8.33	An equality impact assessment (EIA) documented action plan is available for inspection, detailing key objectives, targets and timescales. The organisation reviews the equalities data, and sets targets to address gaps in the recruitment of staff representative of Black and Minority Ethnic (BME) communities.
	8.34	An equality and diversity strategy which includes both staff and service users is developed and produced based on the outcomes of the EIA and review of the equality and diversity policy and procedures and any incidents that have occurred, that determine the need for a review of both practice and procedures.
	8.35	Recruitment procedures state that data is collected on successful and unsuccessful applicant's across protected equality characteristics i.e. ethnicity, age, gender, disability, faith, sexual orientation, religion and belief together with outcomes from exit interviews and feeds into the equalities strategy.
	8.36	There is a proactive approach to working with service commissioners identifying local need and adapting services accordingly.
The effectiveness of the equal opportunities and anti-discriminatory procedures policies and plans are periodically reviewed; targets are set and performance monitored against these.	8.37	The targets are documented and approved in appropriate minutes.
	8.38	Relevant staff are informed of the targets and their performance is monitored against achieving the targets as appropriate.
	8.39	Periodic reviews (at least annual) of statistics and other performance information are compared to targets contained within the plan.

The anti-discrimination policy, equality and diversity policy and harassment policies are implemented and effective.	8.40	Evidence shows that the organisation has made efforts to recruit and implement a workforce that reflects the diversity and cultural profile of service users.
	8.41	There is evidence of specific actions or changes arising from the policies (e.g. changes in recruitment practices, challenges to unacceptable language or behaviour etc.).
Service users are made aware of the above policies.	8.42	Policies are explained in service users' introductory information, hand book etc. including procedures regarding harassment reporting etc. and have been translated on request.
	8.43	Service users can confirm awareness of the policies.
There is a co-ordinated multi-agency approach to tackling discrimination and harassment.	8.44	Notes of multi-agency working, for example, minutes and agendas, named contacts, joint action plans.
There is a planned approach to dealing with hate crime perpetrators.	8.45	There are clear procedures in place for identifying hate crime perpetrators, informing the police and/or taking legal action if appropriate, terminating employment and/or working with perpetrators to avoid recurrence. There are clear links to safeguarding (where appropriate)
There is a planned approach to victim support.	8.46	There is a documented means of responding to victim support including for example; providing or putting victims in touch with forms of support such as counselling, legal advice, mediation etc.
Service users/family/their carer/advocacy are involved in the periodic review of the, equality and diversity policy.	8.47	Notes of involvement or consultation through meetings, focus groups, newsletters etc.
	8.48	Service user involvement is monitored through equalities categories to ensure fair representation.

SECTION 3 - QUALITY ASSURANCES AND QUALITY CONTROL

Quality Assurance is a method of regular and systematic monitoring and evaluation of different areas of a service provision, to improve the quality and standards of the services provided and increase service user's satisfaction. The quality is determined by the feedback from service users/family/their carer advocates/and related professionals.

Standard 9: Service Users' Empowerment and Engagement		
Organisations can continually learn and improve through involving the people who actually use their service. A range of methods of asking service users their views, listening to concerns and compliments and responding to comments raised should be used across services. Not only do organisations benefit from this process, service users may also benefit from their involvement by learning new skills and improving confidence and self-esteem levels. It should be appreciated that not everyone will want to have the same level of involvement in developing services. Opportunities should be offered to everyone, but people should be supported to have as little or as much involvement in decisions about service delivery as they want to have.		
Objectives		**Sources of Evidence**
A service user's involvement strategy has been developed and is in place.	9.1	The strategy is aimed at all service users, and/or their representatives. An action plan to implement the strategy has been developed with service users, and/or their representatives to support successful implementation. The strategy is reviewed annually.
The organisation has taken practical steps to improve the involvement and empowerment of their service users by understanding barriers and drivers and improving the model of engagement activities.	9.2	A service user involvement statement is provided in welcome packs, as well as handbooks for new service users; Individual service users should be absolutely clear about the purpose of any involvement, and can make a fully informed decision to become involved at the level that suits them.
	9.3	Support staff regularly remind service users and/or their representatives about the organisation's complaints procedure, promoting complaints as a means to improve services – "If we are getting it wrong how can we put it right?" attitude. Staff recognise and understand that to provide person centred planning they need to work with their service users and understand their individual needs and preferences; professionally written care notes/logs confirm staff communicate well with service users, offering them choice, in clothes, food preferences, showers etc..
	9.4	Regular review/evaluation of the make-up of service user representation attending involvement activities/ meetings/groups and feedback from surveys by the relevant staff/registered manager, identifies which group of service users have or have not been represented in participation and what steps need to be taken to reach out to those not represented.

	9.5	Performance management processes ensure that service users' involvement is discussed at supervision sessions and team meetings. Constructive feedback from service users is discussed positively. Compliments are shared and concerns are raised in a "what could we do better" discussion, and suggestions for improvements from both the supervisor and supervisee are recorded and evidenced that both staff and service users are involved in service improvement. Training/coaching needs are identified to support the recommended improvements and are implemented as required.
	9.6	Quality questionnaires about the service provided are sent to service users, their families and other stakeholders. Responses are reviewed by the relevant staff/registered manager and suggestions for improvements and service developments help inform the detail of the annual service plan. Minutes of meetings and other publicity confirm the impact of service user involvement.
All staff involved understand the principles and practice of service user participation, and are empowered by organisational structures, processes and management strategies to make it a success.	9.7	There is evidence that the service users involvement plan is monitored by senior personnel and the relevant person/registered manager. The senior management team evaluate the targets/indicators (for milestones of achievement) set to achieve a successful programme, including the number of attendees broken down by ethnicity.
	9.9	Staff need to recognise and address cultural, communication, physical and organisational barriers service users may face regarding involvement Reports on the activities provided, numbers in attendance, and outcomes of the service user involvement programme are reported as part of performance monitoring undertaken at contract review meetings with commissioners.
	9.10	The mapping and evaluation of current baseline activity across the services has informed the development of annual action plans, improving service user experience strategies, policy development and operational procedures. There is clear evidence of service user and/or their representatives views being included in service delivery leading to service improvement, increase in service user satisfaction, and a multi-skilled workforce that is competent to deliver person centred services that give their service users the confidence to have more control over their own lives and to live independently safely in their own homes.

Standard 10: The Social Care Commitment
The Social Care Commitment is the Adult Social Care sector's promise to provide people who need care and support with high quality services. **It is made up of seven *'I will'* statements, with associated tasks. Each commitment will focus on the minimum standards required when working in care. The commitment aims to increase public confidence in the care sector and raise workforce quality in adult social care.**
Leeds City Council expects organisations under contract to sign up to the Social Care Commitment, evidence their commitment and fully complete the organisation's registration on the Department of Health's website.