Creative Support Limited

Creative Support - Manchester Services

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Creative Support - Manchester Services is an independent supported living service where personal care and support is provided to people living in their own homes. This service consisted of four people living communally in two adjoining houses, with 24 hour staff support. This was the first inspection of this service since it was registered with the Commission in October 2013.

This inspection took place on 22 and 23 September 2016 and was announced. The provider was given 48 hours' notice because the location is an independent supported living service for people with learning disabilities and autism spectrum disorder who are often out during the day; we needed to be sure that someone would be in. The inspection was carried out by one inspector.

A registered manager was in post at the time of our inspection who had been registered with the Commission to manage the carrying on of the regulated activity since October 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not all of the people in receipt of care could communicate with us verbally, but those who could told us they were happy with the support they received. They said they liked the staff team and we saw there was a good rapport between people and staff. Safeguarding policies and procedures were in place to monitor and respond to any matters of a safeguarding nature and we saw that historically these had been dealt with correctly by the registered manager. Staff were aware of their personal responsibility to report incidents of a safeguarding nature and they had received training in safeguarding vulnerable adults. Risks that people had been exposed to in their daily lives and within the environments of their homes had been assessed and mitigated against. Accidents and incidents were monitored, analysed and measures were put in place where necessary to prevent repeat events. General environmental checks were also carried out on a regular basis to ensure people remained safe.

Recruitment procedures were robust and medicines were managed safely and appropriately in line with best practice guidance. Staffing levels were sufficient on the days that we visited the home to meet people's needs and they were determined by the level of support each individual needed. Staff were very knowledgeable about people's needs and effective plans were in place to support them to meet these needs. Care plans and risk assessments were regularly reviewed to ensure they remained current and up to date. They were person-centred and described in detail how staff should support people, the characteristics they would need and people's personal behaviours, likes, dislikes and habits.

Staff were trained in key areas relevant to their role such as emergency first aid and the safe handling of medicines. They were also trained in areas such as epilepsy and breakaway techniques, which was relevant to the needs of some of the people they supported. There was a thorough induction package in place and

supervisions, appraisals and staff meetings took place regularly to provide support to the staff team.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken in line with procedures set out in the MCA. Applications to the Court of Protection were currently being considered by people's care managers in the local authority, and the registered manager was working with the local authority to progress these as soon as possible. People's consent to care and treatment was obtained before staff delivered care.

People were treated with dignity and respect and they enjoyed good relationships with staff. The ethos of the service was to promote people's independence and there was evidence that people had progressed in their abilities to look after themselves as a result of receiving care and support from the service. Some people were able to advocate for themselves and others had relatives acting on their behalf. People were supported to maintain their general healthcare needs and their food and fluid intakes were monitored to ensure they ate and drank enough to remain healthy. Specialist input into people's care was arranged as and when needed. Care plans about how to support people, written by healthcare professionals such as psychiatrists were retained within people's care records for staff to refer to.

Complaints received within the service were handled appropriately and feedback was actively sought from people who used the service, their relatives, staff and healthcare professionals with a view to making improvements to the service where necessary.

We received positive feedback about the registered manager and overall leadership of the service. A structured management team was in place which provided support to the service and registered manager. Meetings were held within the service internally and also within the provider's organisation at national and regional level. Quality monitoring systems were robust including a range of audits and checks being carried out in relation to health and safety matters, medicines management, finances, infection control, accidents and incidents and safeguarding issues. The provider had oversight of auditing within the service as regular monthly reports and results of audits and analysis were sent to them. Regular external provider level audits of the service were also carried out by the health and safety team and quality team that were part of the overall provider organisation.

The provider recognised the achievements of both people and staff and issued a range of awards. Social isolation was encouraged and events were held for people who used the service to partake in, if they so wished.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks that people were exposed to in their daily lives had been appropriately assessed and action had been taken to mitigate these risks.

Accidents and incidents were recorded and monitored. Emergency planning had been considered.

Safeguarding policies and procedures were in place and staff understood about safeguarding vulnerable adults.

Staffing levels were appropriate and recruitment procedures were robust. Medicines were safely managed.

Is the service effective?

Good

The service was effective.

People received care that met their needs.

Staff were knowledgeable about how to support people and they ensured that their general healthcare needs were met.

The Mental Capacity Act 2005 was applied appropriately and the provider was aware of their legal obligations under this Act.

Staff received appropriate training, induction, supervision and appraisal. They were supported by the provider to care for people effectively.

Is the service caring?

Good

The service was caring.

People and staff enjoyed good relationships.

People were treated with dignity and respect and encouraged to be as independent as possible.

Both relatives and people were involved in the service.

Advocacy services were available to people should they need them.

Is the service responsive?

Good

The service was responsive.

The care that people received was person-centred as were the care records retained about how to deliver their care.

Monitoring of people's care was carried out daily and action was taken promptly to address any concerns where necessary.

People were supported to pursue activities of their choosing.

Complaints were handled appropriately and feedback from people using the service and others was sought with a view to making changes and improvements to the service.

Is the service well-led?

Good

The service was well-led.

People, relatives and healthcare professionals gave positive feedback about the leadership of the service.

Checks and audits were carried out regularly and there was a culture of driving improvements throughout the service.

The standard of care delivered was monitored appropriately and actions were taken to address any shortfalls.

The provider organisation recognised the contribution of staff and the progress people made towards greater independence.

Creative Support - Manchester Services

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 September 2016 and was announced. The provider was given 48 hours' notice because the location is an independent supported living service for people with learning disabilities and autism spectrum disorder, who are often out during the day; we needed to be sure that someone would be in. The inspection was carried out by one inspector.

Prior to our inspection the provider completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information the provider submitted, plus information that we held internally about the service, including statutory notifications that the provider is legally obliged to inform us of. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We also sought feedback in advance of the inspection from people who used the service, relatives and healthcare professionals linked to the service, via questionnaires, and we used their feedback to inform our judgements. We also contacted Manchester safeguarding adults team, Manchester City Council commissioning team and Manchester Healthwatch for their feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information that they provided us with to inform the planning of this inspection.

During our inspection we spoke with all four people who used the service, although only two people were able to communicate with us verbally. We also spoke with the registered manager, the regional service manager, the service director, the quality service director and three care workers. In addition, we reviewed

the feedback that had been received from relatives and healthcare professionals in their questionnaire responses. During our visit we looked at two people's care records in detail and reviewed the other two people's records, each person's Medication Administration Records (MARs) and looked at a range of other records related to the operation of the service. These operation records included looking at five staff training and recruitment records, care monitoring tools and quality assurance documentation.

Good

Is the service safe?

Our findings

People who could converse with us told us they liked the staff team who supported them and they felt safe when in receipt of care. One person said, "I like them (staff)" and another told us, "They (staff) are friendly and kind". Neither person indicated they had been spoken to, or treated inappropriately by staff when we asked them about how staff engaged with them.

We had no concerns about how staff supported people through our own observations of care; they treated people respectfully and delivered care that was both appropriate and safe. People appeared settled within their homes and they had access to staff 24 hours a day to meet their needs. Risks that people were exposed to had been carefully assessed and measures were in place to safely manage and mitigate these risks. For example, some people had risk assessments in place related to self-neglect and behaviours which may challenge. There was detailed information about the steps staff should take when delivering care to reduce these risks as much as possible. Records showed that risk assessments were regularly reviewed to ensure their content remained current, in line with people's changing needs.

Staff supported people to monitor health and safety matters and risks within their homes. Where they were able to, people accompanied staff when they carried out checks on their properties, for example, looking at the condition of fire-fighting equipment, flooring and fixtures and fittings. The provider delivered the care service people received and they also owned the two buildings in which the four people in receipt of care lived. Tenancy arrangements on a supported living basis between people and the provider, were in place. The provider was aware of their responsibilities as a landlord to keep the properties they owned (where these four people were tenants) in a safe condition and also their obligations as an employer under relevant Health and Safety legislation, such as the Health and Safety at Work Act 1974.

Accidents and incidents that occurred within the service were appropriately recorded, dealt with and monitored. An incident reporting policy was in place and records showed this had been followed in practice. Details of each individual accident or incident had been recorded including what happened, who was involved, immediate follow up actions, could the incident/accident have been prevented and any organisational implications and recommendations. An analysis of accidents and incidents was done on an ad hoc basis approximately every two to three months. The provider had an oversight of incidents that occurred at the service as each individual incident was forwarded to their head office base, as was the analysis done at a minimum on a quarterly basis. The registered manager told us that staff from the provider's head office would ring up to discuss individual events if they wanted more information, clarification or confirmation about responsive actions that had been taken.

Emergency planning had been considered and an emergency action plan was in place for staff to refer to, for example, in the event of a loss of power. Each person had a Personal Emergency Evacuation Plan (PEEP) within their care records which listed the support they would need to evacuate their homes in an emergency situation such as a fire or flood. An on-call system and contact details for management at a variety of local and senior levels was available to staff in the office, should they need support outside of core working office hours.

The provider had detailed safeguarding and whistleblowing policies and procedures in place that provided staff with the guidance they needed to escalate any concerns of a safeguarding nature, should they arise. A flow chart diagram was in place to aid and inform staff about the reporting channels they should follow, both internally, and also externally when relaying concerns to the local authority safeguarding adults team in line with set safeguarding protocols. Staff had received training in the safeguarding of vulnerable adults and were aware of their own personal responsibility to report matters of a safeguarding nature. They displayed a knowledge of the different types of abuse that people could potentially be exposed to and were aware of the internal and external channels through which they should report any incidents of harm or abuse, in order to safeguard the vulnerable people they cared for. The registered manager retained detailed records about any on-going or historic safeguarding matters, including outcomes, and these records showed she worked well with the local authority safeguarding team to progress and conclude investigations. The registered manager kept the Commission informed of safeguarding incidents that occurred when staff delivered personal care.

Staffing levels within the service were determined by people's needs and they were appropriate on the days that we visited. Four people lived in their own home which was two properties that had been converted into one. There were two clearly defined areas of the building and staff were allocated to support specific individuals on each shift. A keyworker system was in place, although all staff supported all people at varying times. Some of the people received 2:1 support from staff, in line with their needs. The care delivered in each area was overseen by the registered manager. Staff told us that the number of staff on duty was sufficient to meet people's needs and they got support from the management structure above them. The registered manager told us that they were in the process of recruiting a senior care worker in the role of 'Supported Living Co-ordinator' to be based at this location. She said this was because although she visited the properties daily, and was available to attend whenever needed, she was also responsible for overseeing the operation of other services locally and wanted a senior person present during day shifts to direct staff as needed in their daily care roles.

Evidence in staff files demonstrated that the provider's recruitment and vetting procedures of new staff were appropriate and protected people. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. The registered manager told us that where they were able, people in receipt of care would attend interviews with new staff and meet them before they were offered the job. She told us this was to ensure that the right staff were selected and also to ensure that staff applying for the post were aware of the varying needs of the people they would be supporting. Matters of a disciplinary nature were dealt with appropriately and records showed that full investigations were undertaken when necessary. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs were met by staff who were of good character and who had the appropriate competence and skills to carry out their jobs.

The management of medicines was both appropriate and safe. Medicines administration records (MARs) were well maintained and reflected that the recording of the administration of medicines was in line with best practice guidance. Personalised plans were in place for the administration of 'as required' medicines detailing when these should be given to those individuals who required them, for example, when they displayed identified signs of being in pain. All of the medicines we checked were within their expiry date and stored in line with manufacturers guidelines. Systems were in place to account for and dispose safely of medicines that were no longer required. Accurate records and signatures of receiving parties were obtained to track medicines that left the home, when people visited friends or relatives and they were staying away

overnight. We saw that some minor issues with the management of medicines had been identified by the registered manager in recent months and they had acted promptly and put measures in place to address any shortfalls and to support staff appropriately where there had been errors in medicine administration. This showed the provider understood their responsibilities to manage medicines safely.

Good

Is the service effective?

Our findings

People gave us positive feedback about the care they received and said it met their needs. One person told us, "I like it here and the staff are great. I can do what I want. They help me". Another person said, "I am happy here. I have no problems; they look after me well". Recent questionnaire feedback demonstrated that people's relatives were happy with the progress their family member had made towards greater independence. Healthcare professionals involved in people's care had commented in the same questionnaires that they found the service approachable, welcoming and professional. One GP commented about how well staff know people and their needs and how they enjoyed good communication with staff and the service overall.

We were satisfied that people received a good service and their needs were met in a timely manner. Staff were clear about people's needs and how to support them appropriately. When we asked staff about the needs and behaviours of particular individuals, they were able to explain these in detail to us and they clarified how they would support these people effectively. The information they gave us tallied with information held in these people's care records and our own observations.

Two people had funded equipment relevant to their needs and one of the rooms in their property had been converted into a sensory room. This had pictures, strobe lamps, colour changing items, colour changing lights and water based visual equipment to help manage sensory sensitivities. Staff said this was a good resource and was used to good effect when people needed this support.

People's general healthcare needs were met. We found evidence that people were supported to access routine medical support or more specialist support such as that from a psychiatrist, whenever this was necessary, or where people indicated they wanted this level of support if they could communicate this verbally. People's nutritional needs were met and well managed. The registered manager told us that no people currently supported by the service had any specific nutritional needs, but that food and fluid monitoring was carried out to ensure people ate and drank in sufficient amounts to remain healthy. People were also weighed regularly to ensure that any significant changes in their weight were identified promptly and medical attention sought. Some people planned their meals and then shopped locally for their food with support from staff. Staff purchased food for other people who were less able, in line with their likes and dislikes, which staff had established whilst caring for them.

Staff told us that communication within the service was good and they had enough information available to them to meet people's needs effectively. Staff meetings took place regularly and handover meetings took place as each shift changed, including written handovers, to ensure that key messages were passed between different changing staff members when they came on shift. Relatives commented in feedback questionnaires that the communication between staff and themselves was good.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental

capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We discussed the Mental Capacity Act (2005) and Court of Protection orders to deprive people of their liberty in a domiciliary setting, with the registered manager and service manager. They told us that people's cognitive abilities were assessed at the point the service commenced and then afterwards, as and when necessary related to individual decisions being made. Management were clear about their responsibilities in line with the Mental Capacity Act 2005 and decision making for those people who may lack the capacity to make decisions for themselves. We discussed the needs of one person supported by the service and a best interest decision that is currently being progressed about them moving on to a flat on their own, promoting a more independent living arrangement. The registered manager confirmed that no person currently using the service was subject to a Court of Protection order to deprive them of their liberty in a domiciliary care setting, but that applications to the Court of Protection were currently being considered by people's care managers in the local authority, and they were working with the local authority to progress these as soon as possible. The provider informed us that should any concerns or issues arise in the future in respect of a person's capacity levels, they would always liaise with their care managers to ensure that capacity assessments were carried out and decisions were made in people's best interests.

In all aspects of their daily lives people's consent was sought before staff delivered care. For example, the registered manager told us that one person had refused their medicines that morning. At a slightly later time a different staff member supported this person to take their medicines, which they did successfully. Their right to refuse their medicines initially was respected. This demonstrated that staff understood people's right to consent to care and they respected this right. Where they were able, staff had discussed consent to different elements of their care with people and people had signed consent forms in their care records. For example, we saw there was a consent form in place which covered staff having keys and access to people's homes, assistance with the administration of medicines and people's preferences about the gender of the staff who supported them. This showed the provider had consulted with people and obtained their consent to care and support, wherever possible.

Staff told us, and records showed that they received regular training relevant to their roles, via e-learning and face to face courses. Staff training requirements were monitored at the provider's head office and arrangements were made for training to be refreshed as and when required. This ensured that staff were supported to deliver effective care as their skills were kept up to date. Staff had completed training in a number of key areas such as the safe handling of medicines and emergency first aid, as well as some specialised training relevant to their roles, including autism awareness, epilepsy and breakaway techniques. One member of staff told us, "I have done all the training that I should have". Another member of staff said, "I have training coming up. I have done a lot of training". An induction programme was in place and completed by new members of staff at the point they commenced employment with the service. The care certificate was being embedded into this induction for all new staff. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and brought into force in April 2015. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers. This showed the provider invested in their staff team and supported them to maintain and develop their skills.

Staff told us, and records confirmed that supervisions took place regularly and appraisals annually. All of the

staff we spoke with said they found these one to one sessions with their manager useful and supportive. Supervisions and appraisals are important as they are a two-way feedback tool through which the manager and individual staff can discuss work related issues, training needs and personal matters if necessary. Staff also had individual personal development plans in place tailored to their own developmental needs.

Good

Is the service caring?

Our findings

Staff and people enjoyed good caring relationships. We observed staff delivered care and support in a kind, friendly and professional manner and many pleasant and respectful interactions took place between people and staff, and people and the registered manager, during our visit. Staff regularly praised people and they responded to this encouragement. For example, we heard staff telling people they had "done very well" at a particular task and thanking them for completing certain activities such as tidying their living space, or taking their medicines. When people were assisted by staff they thanked them and staff replied by saying "you are welcome" and "thank you". Staff used positive encouragement and reinforcement and regularly asked people how they were, whether they had enjoyed their food or an activity and they spoke with them about their lives. The relationships and interactions we saw during our inspection appeared to have a positive impact on people's wellbeing.

People told us they liked the staff team and got on with them well. One person said, "The staff are nice". When we asked another person for their opinion about the staff who supported them, they said, "I like them".

Our discussions with staff revealed there was one person in receipt of care from the service with a diverse need in respect of their religion under the seven protected characteristics of the Equality Act 2010 that applied, namely; age, disability, gender, marital status, race, religion and sexual orientation. This related to eating halal meat and staff confirmed that this person was always provided with halal meat, which was specifically bought for them. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. Staff had received training in equality and diversity and they were knowledgeable about treating people equally and in line with their own individual and differing needs.

Staff were motivated and reflected pride in their work. They talked about people in a way which demonstrated they wanted to support them as much as possible and provide a high standard of care. People were treated with dignity and respect, for example, staff knocked on people's bedroom doors before being invited to enter, so that their privacy was respected. In line with one person's needs, staff respected their right to be alone in the kitchen to make their own breakfast and we saw they removed themselves from the immediate area waiting to be invited back in. Conversations about people and their care needs were held by staff discreetly during our visit and this ensured that their dignity was protected.

The ethos of the service, and the nature of independent supported living as a support model, naturally lends itself to promoting people's overall independence. There was evidence that people had progressed in their abilities to look after themselves as a result of receiving care and support from the service and that their needs and behaviours had changed. One person was hoping to move into their own individual flat alone, and it was felt that another person would benefit from living in their own flat with personalised 24 hour a day support from staff. These matters were being looked into at the time of our visit. Staff told us they assisted people with activities of daily living such as dressing and shaving, but they encouraged people to do as much for themselves, such as buttoning their shirts independently, once they had put them on. One

person was able to enter the community alone but others needed supported on a 2:1 staff to person ratio. People had differing levels of independence but within the boundaries of their abilities and needs, they were encouraged to become as independent as possible.

The registered manager shared with us two success stories which showed the service had worked in partnership with people to develop their independence from being more reliant on others, to being able to do much more for themselves. These stories showed the service had encouraged social inclusion and developed people's abilities, skills and confidence. One person, who had in the past regularly expressed a desire to change from one service provider to another, had been receiving care from this service for over five years, showing a level of happiness and contentment with the support they received.

Staff provided people with explanations about their care, activities and choices available to them. One sheet in a person's care record had not been fully completed and we saw a member of staff took this information and explained it to the person, before returning it completed with their agreement. Staff communicated with people well throughout our visit and explained what they were doing, either as they went about their work completing household tasks, or when they were directly supporting people with their care.

People and their relatives were involved in the service. The registered manager told us that when potential new staff were interviewed people from the service were invited to attend, if they had the capacity to understand, so that they could give their opinion of the potential new staff member and see if they liked them. People's relatives visited regularly and they worked in conjunction with the provider to promote care that was in people's best interests. One person had also completed fire awareness and health and safety training themselves through the service, to develop their own skills and knowledge.

The registered manager told us that two people in receipt of care were able to advocate for themselves and did so regularly, requesting meetings with their care managers as and when needed. The other two people in receipt of care from the service were supported with advocacy, due to their capacity levels, by their families and staff. The registered manager confirmed that nobody currently accessed the services of a formal advocate, but should this be needed, it would be arranged via their care managers in the local authority. An advocate is a person who speaks up on behalf of another person, to ensure their views and wishes are expressed and their voices heard. They always act in people's best interests where people do not have the capacity to express their own views.

Good

Is the service responsive?

Our findings

The care people received was person-centred. Depending on their needs, some people had structured routines in place that they were familiar and comfortable with. Other people had no set routines about what they did with their time and staff supported them to set and achieve goals each day, as they wished. One person had a 'plan' with pictorial prompts which they and staff used regularly to reinforce the format their day would take. This was to inform the person and provide structure, order and routine to their day, which assisted with managing their autistic needs and behaviours.

People described what they were going to do on the days that we visited. They had made these choices themselves in line with what they wanted to do. Staff told us this was the way the service operated, because it was a supported living service where staff supported people to live their lives, in the way they wanted to. We saw, and people told us they had choices about all aspects of their lives, from the food they ate, to where and how they spent their time. One person was going to the cinema with staff and to buy a new media appliance when we visited. Another person was going to attend the provider's head office 'Cyber Cafe' facility, where there were computers they could access and where cookery, drama, arts, crafts and photography were offered to people in receipt of care, on a sessional basis. People were supported to pursue activities of their choosing.

Each person had care records in place that were written in the first person and very person-centred. They provided staff with a range of information about the person, their needs and any risks that they may be exposed to in their daily lives. There was information about how to communicate effectively with each individual, what certain behaviours they displayed may mean, what is important to them, how they like their week to look, who is in their lives, day and night time routines, foods they liked and disliked and how they liked to make decisions, amongst other things. A holistic assessment was in place for each person that contained information, for example, about their life history, medical history, social skills, aspirations, advocacy needs and their social behaviours and needs. Risk assessments, and steps that needed to be taken to mitigate risks, were clearly documented and there was a list of characteristics that staff needed in order to support the person effectively. External healthcare professionals involvement in people's care was evident and where professionals such as clinical psychologists had produced care plans and guidance about how to support people this had been retained within people's care plans and formulated into the care records developed by the service. Care records were regularly reviewed and updated as people's needs changed.

Care monitoring tools such as records tracking people's behaviours, incidents and accidents, their nutritional intake, weights and their night time routines and sleeping patterns, were in place and well maintained. Handover meetings were also carried out when each staff shift changed and written handover sheets were transferred to the oncoming shift with key information and actions to follow up. At the point of handover of shift, checks on finances and medicines were carried out to ensure that any anomalies were identified and addressed. Daily notes about people's moods, behaviours, activities, appointments and any further important information were well maintained and informed the reader about what that person's care had looked like that day. A staff communication book was in place and an appointment diary, both of which

we saw staff used and referred to throughout the day. This showed the provider had systems in place to ensure continuity of care as much as possible and to monitor and track any changes in people's needs as promptly as possible.

A detailed complaints policy and set procedures were in place. Records showed that complaints were handled appropriately and actions were taken where necessary to feed back concerns to staff about their actions or conduct in different situations. Letters of apology were seen where the provider had written to the complainant and accepted responsibility for any errors on their part. Detailed records including any investigations into a complaint were retained for future reference.

Feedback from people using the service, their relatives and external healthcare professionals, was actively sought via questionnaires. In addition, where people were able, they could feedback their views at any time to staff or the registered manager. Two people had decided that they did not want formal 'Resident's meetings' to take place but the registered manager had ensured they were regularly asked for feedback. One person had a book in which they wrote down their feelings as they were not always able to express these verbally and they shared this with staff. The registered manager told us they were able to ask the person for feedback via this route and that all feedback was reviewed, and in response to this feedback, changes to practices and improvements were made where necessary. Staff told us they could approach the manager at any time with any feedback they had, or alternatively there was the opportunity to feedback their views in supervisions or at staff meetings. This demonstrated that the provider actively sought the views of people using the service and others involved in the delivery of care, with a view to assessing that information and making improvements within the service.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post who had been registered to manage the carrying on of the regulated activity at the service since October 2013. The registration requirements of the service had been met and we were satisfied that incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009 within the 12 months prior to our inspection.

In their statement of purpose for this service, the provider listed their aims as the; "Provision of flexible, person centred care and support"; "Positive support to promote routine and structure to developing daily living skills"; "Promoting a positive environment in relation to sensory needs and consistency in communication"; and "Support in empowering individuals to be more independent and personal development providing a truly person centred service and quality of life". The findings of our inspection indicated that at this service, the provider achieved their aims.

People and staff gave positive feedback about the leadership of the service saying they could approach the registered manager at any time about anything. One person told us, "(Name of registered manager) is great. I can speak to her" and another person told us, "(Name of registered manager) is nice". We observed how the registered manager engaged with people who used the service and saw that she had a very good rapport with each individual person. Staff told us they felt supported by management. One member of staff commented, "(Name of registered manager) deals with things. If anything is taken to her she has meetings with people about it. I can talk to (Name of registered manager) at any time". Another member of staff said, "(Name of registered manager) is good. She is firm but fair. If there is something raised it is said and then we move on. She is definitely approachable and you can go to her about things". Healthcare professionals linked with the service described the staff team as "very professional" and "welcoming", in their responses to questionnaires they had completed. Morale within the staff team was good and they seemed happy, content and appropriately supported by the registered manager to fulfil their roles.

The provider had a structured management team in place, with the registered manager being supported by a regional service manager and above them, a range of directors responsible for different areas of the provider's organisation on an operational, quality and finance basis. The registered manager told us that staff from the provider's organisation visited the service regularly to carry out a range of audits and checks to ensure the service was operating effectively and appropriately in line with the provider's objectives and aims. The registered manager confirmed the structure and levels of support within the service were very good.

Staff meetings within the service and then at a higher level with the provider organisation took place regularly. Minutes showed that in relation to this service the registered manager kept staff informed about important matters and changes to the service and there was regular discussion about issues such as staff morale, safeguarding, complaints, training and health and safety. These meetings were also used to deliver corporate messages to the staff team. Regular handover meetings and the use of communication books, care monitoring tools and recording of daily issues and activities within the service, supported continuity of

care and provided accountability for staff. People's personal care records and information were stored securely.

At a regional level, national registered manager meetings were held quarterly. Social care governance meetings amongst senior management in the provider's organisation were held monthly where issues such as notifications, incidents, complaints, quality improvement and risk ratings for individual services were discussed. Quality group meetings were held bi-monthly at a higher level to review inspection and governance information. The quality services director told us the provider's leadership team visited a service(s) in one of each of the four different strands of service type delivered by the organisation, approximately once a month. 'Service user forums' were also held throughout the year, where people who used services were invited to attend an event local to them, where they could give feedback directly to the provider's overall leadership team.

Quality monitoring systems were in place to ensure that the service delivered was effective and issues were identified and improved where necessary. For example, in terms of staff practice medication competency assessments and observations of staff practice were carried out. An 'Evidence of competency' file had recently been introduced into the service where staff competencies within their roles was assessed and retained. This included testing staff knowledge via paper-based tests in a range of different areas, including safeguarding, dignity and medicines, and in addition observations of staff practice that were carried out were retained within this file. Staff performance was also assessed and monitored through regular supervision sessions and annual appraisals. Feedback about the service was also gathered through questionnaires and surveys issued to people, their relatives and external healthcare professionals linked to the service. This showed senior management had an overview of the service and regularly monitored its effectiveness.

A range of different audits and checks were carried out internally to monitor care delivery and other elements of the service. The registered manager was required to completed a monthly performance monitoring audit which included looking at, for example, infection control matters, medication, safeguarding incidents, health and safety checks, complaints and supervisions done. Checks on stocks of medicines and personal finances were undertaken at the point of each staff shift handover, to ensure that any anomalies were promptly identified and investigated. Analysis of accidents and incidents that had occurred, were completed regularly also. Health and safety audits/checks around people's homes were carried out daily, weekly or monthly in line with best practice guidelines. There was evidence that where issues were identified, action plans were created and steps had been taken to ensure matters were addressed. For example, we saw that in recent months an issue had been identified with the management of medicines via the analysis of accidents and incidents, and so the registered manager had introduced extra checks on medicines stocks at the point of handover of shift and some staff had been reassessed in respect of their competency to administer medicines. The auditing and checking within the service showed that systems were in place to monitor the service delivered and to address any shortfalls and drive improvements, should this be necessary.

The monthly performance monitoring audit completed by the registered manager was sent to the regional services manager for review. Any serious issues that were identified were then escalated to higher management within the provider's organisation to be reviewed and addressed. The provider had also issued a 'Manager's monthly checklist' corporately which was used to direct the registered manager to review, for example, care records and whether supervisions had been completed. The registered manager told us that the provider carried out their own full internal audit of the service on approximately a six to twelve month basis and the service was assigned an action plan for improvements (if necessary) as a result of these internal audit findings. The registered manager also told us that the provider's quality team did financial

audits of the service and the health and safety team did environmental audits, at intermittent periods. The provider's quality team were available to carry out audits at the request of the registered manager. For example, when the registered manager noticed some recent issues with medicines management within the service, she requested the quality team come out and carry out an audit of medicines, which they did. We viewed the report produced from this audit and the action plan issued to the registered manager to implement improvements. This showed there was a culture of questioning practice and a drive to continually improve standards within the service.

The provider operated a number of award schemes, including awards for 'Service user of the month' designed to recognise people's progress towards greater independence and a number of staff awards for teamwork and individual work undertaken. There was also a 'Staff team of the month' award given to services as recognition for their hard work, in relation to all other services in the provider's organisation portfolio. A staff reward scheme was in place giving staff discounted purchases at a range of retail outlets and staff long service awards were given out to staff once they had worked for the provider for periods of five, ten and 15 years.

The registered manager and regional services manager also told us that individual services could apply to the provider organisation for a grant to fund activities for people. They told us about an event that they had organised which had been funded in this way, where services run by the provider in the South Manchester area had arranged a joint street party for the Queen's 90th birthday celebrations. They told us this event had been a success and people had thoroughly enjoyed themselves. Each year the provider also held a football competition between services, which included people and staff from a variety of different services if they wished to be involved. This showed the provider promoted social inclusion and community involvement, and they recognised the achievements of both people and staff.