Time 4 U Ltd

GUTU

Inspection report

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Date of inspection visit:
18 January 2018

Date of publication:
07 February 2018

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

This inspection took place on 18 January 2018 and was announced.

This service provides personal care and support to eight younger adults living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is also a domiciliary care agency. It provides personal care to people living in their own homes. This supported living and domiciliary care agency meets the needs of people with learning disabilities, autism or people with more complex health needs such as epilepsy. The service is run from an office in Chatham.

A registered manager was employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection report for GUTU was published on 12 July 2017 following a comprehensive inspection which took place on 9 May 2017. At that inspection, we found six breaches of the legal requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to Regulation 9, Person centred care; Regulation 11, Need for consent; Regulation 12, Safe care and treatment; Regulation 17, Good governance; Regulation 18, Staffing; Regulation 19, Fit and proper persons employed. We asked the provider to take action to meet the regulations.

When we completed our previous inspection on 12 July 2017, we also recommended that the provider ensures people's wishes and preferences were documented and respected. At this time this topic area was included under the key question of Caring. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this area has been included under the key question of Effective. Therefore, for this inspection, we have checked that this recommendation has been met in the Effective domain.

At this inspection, we found sufficient improvements had been made. At the last inspection, the provider was also the registered manager. At this inspection the provider had employed an experienced manager who had become the registered manager. This had assisted the provider to make improvements to the service and meet the Regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new registered manager had been recruited with experience of managing learning disability services and for people who had behaviours that could cause harm to themselves or others. Although they were based in an office, the registered manager spent time each week in each service, getting to know people and staff and offering support where needed.

The registered manager involved people in planning their care by assessing their needs based on a person centred approach. People could involve relatives or others who were important to them when they chose the care they wanted. The care plans developed to assist staff to meet people's needs told people's life story, recorded who the important relatives and friends were in people's lives and explained what lifestyle choices people had made. Care planning told staff what people could do independently, what skills people wanted to develop and what staff needed to help people to do.

The registered manager was a train the trainer for the organisation in relation to the Mental Capacity Act 2005 (MCA). The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA). Staff received training about this.

Staff assessed and treated people as individuals so that they understood how they planned people's care to maintain their safety, health and wellbeing and choices. Risks were assessed within the service, both to individual people and for the wider risk from the environment people lived in. Actions to minimise risks were recorded. Staff understood the steps they should take to minimise risks when they were identified. The provider's health and safety policies and management plans were implemented by staff to protect people from harm.

The registered manager and the provider had demonstrated a desire to improve the quality of the service for people with a learning disability by listening to feedback, asking people their views and improving how the service was delivered. People, their relatives and staff felt that the service was well led. They told us that managers were experienced, understood people's needs, were approachable and listened to their views. The provider and registered manager continued to develop business plans to improve the service.

People were often asked if they were happy with the care they received. The provider offered an inclusive service. They had policies about Equality, Diversity and Human Rights. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, by telephone, or by using formal feedback forms.

The provider met their legal obligations by displaying their last inspection rating in their offices and on their website.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The provider recruited staff with relevant experience and the right attitude to work with people who had learning disabilities.

New staff and existing staff were given an induction and on-going training which included information specific to the people's needs in the service. Staff were deployed in a planned way, with the correct training, skills and experience to meet people's needs.

The provider trained staff so that they understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise any concerns they may have. Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these happening again. Staff were trained about the safe management of people with behaviours that may harm themselves or others.

Staff received supervision and attended meetings that assisted them in maintaining their skills and knowledge of social care.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink. Pictures of healthy food were displayed for people and dietary support had been provided through healthy eating plans put in place by dieticians. Staff supported people to maintain a balanced diet and monitor their nutritional health.

There were policies and procedures in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health.

The quality outcomes promoted in the providers policies and procedures were monitored by the management in the service. Audits undertaken were based on cause and effect learning analysis, to improve quality. All staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice.

Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

Working in community settings staff often had to work on their own, but they were provided with good support and an 'Outside Office Hours' number to call during evenings and at weekends if they had concerns about people. The service could continue to run in the event of emergencies arising so that people's care would continue. For example, when there was heavy snow or if there was a power failure at the main office.

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.

People experienced a service that made them feel safe.

Individualised and general risks were assessed to minimise potential harm.

Staff knew what they should do to identify and raise safeguarding concerns.

The provider understood how to report safeguarding concerns and notified the appropriate agencies.

The provider used safe recruitment procedures and general and individual risks were assessed. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink to maintain their health and wellbeing.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 was understood by the provider and staff received training about this.

Is the service caring?

Good

The service was caring.

Staff used a range of communication methods to help people engage with their care.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff provided care to people as individuals. People were provided with the care they needed, based on a care plan about them.

People could take part in activities and socialise according to their lifestyle choices.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The provider operated systems and policies that were effective and focused on the quality of service delivery.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

Staff understood they were accountable for the quality of the care they delivered.

GUTU

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 was a comprehensive inspection. We re-inspect services that have been rated as Requires improvement within 12 months of the last reports publication date.

The inspection took place on 18 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by one inspector.

We reviewed the information we held about the service. Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

Four people and one relative told us about their experience of the service. We spoke with eight staff including the provider, registered manager, operations manager, human resources director, two team leaders and three care workers. We contacted two health and social care professional for feedback about the service.

We looked at records held by the provider and care records held in the office. This included three people's care plans and the recruitment records of five staff employed at the service and the staff training programme. We viewed a range of policies; medicines management; complaints and compliments; meetings minutes; health and safety assessments and quality audits. We looked at what actions the provider had taken to improve the quality of the service.

Good

Is the service safe?

Our findings

At our last inspection on 9 May 2017, we identified breaches of Regulation 12, Regulation 18 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider, who at that time was also the registered manager had failed to adequately assess and mitigate risks to people and staff. Medicines had not been managed effectively. The provider had failed to deploy sufficient numbers of staff and the provider had not established and operated effective recruitment procedures.

At this inspection, we found that sufficient improvement had been made. The provider and registered manager had taken a number of steps to improve the management of risks.

One person told us, "I can talk about being safe or unsafe, I can talk to staff about it." Another person told us, "The staff make you feel safe, they look after me properly." Another person said, "I feel safe when they [Staff] understand me and when I am safe in my home."

A relative told us about a situation where the staff had supported their son to be less anxious. This had made home feel safer and he was now doing more activities outside of his home. The relative said, "He really enjoys going bowling, they [staff] are doing more things with him. He is definitely less anxious as he had a failed placement before."

The registered manager assessed risks to people's individual health and wellbeing. For example, they assessed people's care needs, mobility, nutrition and communication. Audits of medicines and specific risk to people from the care being delivered were in depth and reviewed with frequency to maintain safety. Where risks were identified, people's care plans described the actions care staff should take to minimise the risks. If the actions taken to minimise identified risks restricted people's rights, their consent was sought or their rights were protected with the guidelines set out in the Mental Capacity Act 2005. For example, to maintain safety people may need constant staff supervision when in the community for their safety. We found that people were protected by staff following people's assessed needs.

The medicines systems had been reviewed so that people received their medicines safely to protect their health and wellbeing. Medicines were administered safely by care staff who had specialist training in this area. The registered manager had delegated a lead role to a team leader who oversaw the correct management of medicines. Medicines were ordered, stored and managed to protect people. 'As and when' required medicines (PRN) were administered in line with the providers PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Staff followed the provider's medicines policy. Staff described to us in detail how they followed the provider's medicines policy. People were able to refuse or consent to allow staff to administer medicines for them within the Mental Capacity Act 2005. The registered manager checked that staff followed the medicines policy and that they remained competent by checking staff knowledge and practice when they administered medicines. Competency checks were recorded and a list of staff authorised to administer medicines was kept. Medicine audits were carried out. Physical quantities of stock and quantities that

should have been remaining were checked at each change of staff. Staff had a good understanding of safe labelling. For example, they told in detail how they checked and recorded that the amounts matched the actual amounts left and that liquid medicines had a 'date of opening' recorded on the label and that they would, 'follow the instructions for use by dates.' Staff administering medicines were provided with training so that they understood the broader principals of medicine's safety and record keeping.

People were protected by staff who understood their responsibility to record the administration of medicines. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff. The MAR sheets were being completed correctly by staff, there were no gaps on the MAR records. We saw records of referrals to GPs and of staff seeking advice from other external professionals when required. Records showed that medicines were reviewed with people's GP's.

The registered manager planned staffing based on people's needs. There was a staff deployment rota, but for consistency, the staff normally worked with the same groups of people. The rota showed and staff we spoke with confirmed that enough staff were deployed to enable people's individual needs to be met and for care to be delivered safely. Most people benefited from 1-1 staffing input and additional staff were made available so that people could remain safe when accessing their local community. A relative confirmed that staffing levels met their son's needs. This minimised the risks of harm.

The registered manager had improved the systems in place for robust staff recruitment. For example, staff had to account for gaps in their employment histories. The new employment application forms made this clear. Staff files confirmed references were taken up before employment started. The provider's policy about safe recruitment was up to date. People were protected by these safe recruitment practices, minimising the risk of receiving care from unsuitable staff. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications relevant to the role. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

The provider assessed risks to the environments people lived in to protect them and staff from potential hazards. Records showed that safe systems of work had been implemented via regular health and safety checks of the people's homes. In the supported living service, staff checked the fire alarm systems and assessed people's abilities to respond to evacuation drills. Essential supplies such as the water, gas and electricity were the responsibility of the premises landlord, but staff and relatives told us that the premises were kept well maintained and that staff had access to a list of maintenance companies they could call if things went wrong.

There were policies about dealing with incidents and accidents. The provider's policy set out that incidents and accidents should be recorded, investigated and responded to; this reduced the risk of future incidents. Staff received training about how to report incidents and accidents to the registered manager. The recorded incidents we saw mainly related to incidents of challenging behaviours. These records showed that the incidents had been fully investigated and actions taken to minimise risk. For example, one person smashed a window, the investigation looked at potential causes for this and changes had been made to the staff routines. This had reduced the risk of the incident reoccurring. The staff training programme included specialised training to a recognised national standard in the management of challenging behaviours. It was clear that new and existing staff had a good level of skill and training to manage people with challenging

behaviours. This view was supported by feedback form people's relatives.

People were protected from the risks of potential abuse. The provider had a safeguarding policy that informed staff about their responsibilities to safeguard people and what constituted abuse. Staff received training in safeguarding, knew what signs to look out for and now felt confident the management team would listen to and act on any concerns they raised. Staff told us they understood how abuse could occur and how they should report abuse. They clarified this by telling us about scenarios of abuse they may encounter and how they would respond. For example, if staff noticed bruising or changes in people's behaviours. Staff we spoke with were confident they could challenge any poor practice within the service and report it appropriately. Staff had read and understood the provider's whistleblowing policy.

The registered manager understood how to protect people by reporting concerns they had to the local authority and protecting people from harm. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse.

Detailed daily records were kept by staff. Records included personal care given, well-being, concerns to note and food and fluids taken.

The management remained available via an on call system and were often on site in response to calls made to them by staff who needed help or advice.

People were protected from potential cross infection. Staff received infection control training. Staff told us they always had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

At our last inspection on 9 May 2017, we identified breaches of Regulation 11 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received appropriate training in order to meet the needs of people they provided care and support to. The principles of the Mental Capacity Act 2005 had not always been followed. Relevant consent to care and treatment had not always been gained.

At this inspection, we found that sufficient improvement had been made. The provider and registered manager had taken a number of steps to improve the management of staff inductions and training and the application of the Mental Capacity Act 2005 (MCA 2005).

One person said, "The staff are very pleasant and they arrive on time." Another person said, "The staff talk to me and they understand my needs. They [staff] can always reassure me and keep me in a good frame of mind." Another person said, "When I feel down the staff see me feeling low and they help me pick up again."

A relative said, "Since GUTU took over the care he [son] looks healthy and looks great, his normal self is coming back. They [staff] do ask for advice a lot more from me. They have been willing to try things. They have the right staff."

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The staff told us they had received training to carry out their roles. Staff said, "The training has helped me with my role, it opens up your learning, especially the one about autism get to understand the client more." Records showed staff had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. We checked the effectiveness of the challenging behaviour training staff received. Staff responded in line with care plan guidance for the management of people's challenging behaviours. For example, they understood how people communicated they were becoming agitated and the potential reasons for this, called behavioural triggers. Knowing this enabled staff to avoid situations that could cause challenging behaviours. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development.

New staff confirmed they completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Induction processes were recorded for each member of staff. Staff worked through the Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised.

The registered manager checked how staff were performing through a programme of recorded supervisions (a one to one meeting) and an annual appraisal of staff's work performance. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff confirmed to us

that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings. Staff supervisions were planned in advance and recorded. We reviewed team meeting and supervision notes. These indicated managers were supporting a learning culture through discussion about important issues affecting staff work. For example, safeguarding and infection control. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings and team meetings.

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA 2005.

The service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. Staff had received training in MCA 2005 and understood their responsibilities under the act. Where people lacked capacity to make more complex decisions, for example, deciding where they should live, their relatives or representatives and/or relevant healthcare professionals were involved to make sure decisions were made in their best interests. People's consent and ability to make specific decisions had been assessed and recorded in their records. For example, people had signed their consent to the care and support provided. People were making day to day decisions and these were respected by staff.

All of the people with a learning disability currently using the service were placed by a local authority. Before being placed, people's needs had been holistically assessed by health care and social work professionals. These assessments provided in depth analysis of the care people needed and how people's care should develop. It included their lifestyle choices, freedoms and independence. The provider used the holistic assessment and carried out their own initial assessment for each person to make sure they could meet people's needs. The provider's assessment checked the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The provider also assessed people's dependency levels to capture how much staff care was required and how independent people could remain. The provider's processes involved people and their family members in the assessment process when this was appropriate. Capturing information about people was an evolving process.

The initial assessments led to the development of a person centred care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist and learning disability teams. People accessed a range of health and wellbeing services. For example, podiatry and dental care. Where people's health was at risk from not drinking enough a plan was in place to monitor and respond to the risk. For example, people had been assessed by a speech and language therapist (SALT) or other professional who advised the staff about managing health issues like weight management and diabetes. When needed, staff recorded what people drank or ate in their care plan. People's nutritional risk and allergy needs were shared with staff delivering care so that they were consistent when meal planning with people.

We found that staff had the skills required to care and support the people who received the service. People

were supported with their agreed and recorded daily routines by staff. People's health needs were monitored by staff. For example, people received one to one, 24/7 staff support for epileptic seizures if they were at risk. Staff understood peoples need well.

Good

Is the service caring?

Our findings

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. People told us that staff were kind, friendly and respectful. One person said, "They do treat me good." Another person said, "They [staff] treat me well, with respect and dignity." Another person said, "The staff are very pleasant." Another person said, "The staff treat me as an adult and give me my choices to make."

A relative told us that staff involved them in their sons care. They said, "I went bowling with him the other day. Had conversation with his key worker, they are really knowledgeable about his needs, they explained the new ways he is communicating. Staff do hold back and give us space as I am his Mum, they understand this".

The care people received was person centred and met their most up to date needs. People's likes and dislikes had been recorded in their care plans. Staff encouraged people to be as independent as possible.

Staff we spoke with saw their roles as enablers for people. Staff told us about how they assisted and encouraged independence rather than just doing things for people. For example, one member of staff said, "We support them to learn life skills." Another said, "When cooking meals, the person would not bother, but now the person is engaging in cooking, like cooking rice they will put water in pan." And, "Recently they have started going to the fridge to get things ready for cooking." Another member of staff said, "My colleagues are all very caring and very supportive."

The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights (EDHR). These were accessible to staff and EDHR choices were included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. Staff knowledge of EDHR was discussed at recorded supervisions meetings with the registered manager. Staff we spoke with demonstrated to us how they delivered care respectfully. For example, one person did not eat pork due to their cultural background. Staff told us they respected this and went further by making sure that staff working with the person did not take any pork products into the person's home.

Staff we spoke with were friendly and happy to provide care. Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. We found that people were supported by caring staff that were sensitive in manner and approach to their needs. Staff described how they delivered friendly compassionate care. They told us how they made sure that people were comfortable and relaxed in their presence. Staff described how they made sure people had all they needed. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations.

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person

centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

Information about people was kept securely in the office and the access was restricted to senior staff. The registered manager ensured that confidential paperwork was regularly collected from people's homes and stored securely at the registered office. Staff understood their responsibility to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

At our last inspection on 9 May 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care and support was not person centred and had not been assessed in line with their preferences.

At this inspection, we found that sufficient improvement had been made. People's care plans had been consistently completed and included information about people's life histories and aspirations.

One person said, "They involve me in my care and help me to be independent. I am asked my views at our monthly house meetings." Another told us they knew how to complain if needed. Another person said, "I can talk with staff [managers] freely about my feelings and concerns and I feel comfortable to complain if I needed to."

A relative said, "The health care is looked after well. Do joint decisions. They [staff] do keep me up to date. In the beginning they did not do this. It's changed a lot. We spent his birthday with some of the family, they decorated his home with birthday balloons etc. They included whole family." And, "I always feel like I can call X, [registered manager]. I do trust their view. Lots of the staff not on shift popped in on Christmas day to wish him a happy Christmas."

People received personalised support which met their specific needs. Each person had an up to date care plan which set out for staff how their needs should be met. Care plans were personalised and contained information about people's likes, dislikes and their preferences for how care and support was provided. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff. Care plans covered all aspects of people's daily living and care and support needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, emotional feelings, cultural needs and dignity and independence. People's cultural and sexuality needs were identified in the support required by each person. For example, one person whose first language was not English was supported by a member of staff who spoke their first language. The person had also been enrolled on an English language course to help them develop their communication skills. If people still chose not to receive care from certain staff, this was respected as their decision at that time. The registered manager tried to match staff with people so that a good professional working relationship could develop; this had worked well. A relative said, "I can see that staff have built a good relationship with him." Staff said, "Care plans are kept up to date. I read them often."

The provider used appropriate personalised care planning formats for people with a learning disability. People used lots of photographic and pictorial information in their care plans to assist staff and their understanding. For example, keeping safe from abuse or places they liked to visit. This gave people some interest and ownership of the information about them.

Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us

how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs. They said they also supported people to be able to take part in activities in the community. The staff showed in discussion with us they understood people's conditions and how they impacted on their life. For example epilepsy or behaviours other may not understand.

People had a routine for one-to-one or two-to-one staff support in the community. This included participating in leisure activities, going to the pub for lunch and personal shopping. Staff were allocated to people's activities based on their skills and experience. Activities were recorded. This meant staff could understand and meet this person's individual needs. Staff helped people to stay in touch with their family and friends.

Person centred reviews took place with health action plans and communication passports in place. Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and their access to health services. Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. For example, if they were admitted to a hospital.

The provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was sent to people at home. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. There had been one complaint received in the last twelve months. This complaint had been dealt with in line with the provider's policy.

Good

Is the service well-led?

Our findings

At our last inspection on 9 May 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager and provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided.

At this inspection, we found that sufficient improvement had been made. We found that the provider had implemented good quality assurance systems and used these principles to critically review the service.

One person said, "Time 4 U Ltd is a good company. Communication with managers is very easy. They deal with any problems fast and professionally." Another person said, "The service is run very well."
A relative said, "I can see the registered manager has a good relationship with staff. I can see the improvements."

A member of staff said, "The management always give us feedback, there is no hide and seek, its open door." Another member of staff said, "Work very well as team, we have good communication, hand overs also communicate about how the people are."

We looked at the arrangements in place for quality assurance and governance in all areas. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their services. The registered manager completed monthly audits of all aspects of the service, such as medicines, personnel, learning and development for staff.

The registered manager often visited each service and also carried out a series of audits either monthly, quarterly or as and when required to ensure that the service runs smoothly, such as infection control. We found the audits routinely identified areas they could improve upon and the registered manager produced action plans, which detailed what needed to be done and when action had been taken. We saw the registered manager checked people's care plans, risk assessments and daily logs to ensure they were up to date and completed to a good standard. Keeping people's care reviewed meant that their current needs were always met.

The provider proactively sought people's views and took action to improve their experiences. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The bi annual questionnaires asked people what they thought of their care, the staff, the premises, the management and their daily living experience. The findings of the survey in October 2017 showed a progressive improvement in people's satisfaction from the May 2017 survey. 'Residents and relatives' satisfaction surveys showed the feedback was positive from the people using the service and relatives of people who used the service. Other meetings were advertised and took place for people who used the service and for staff.

Staff told us that they had been employed at GUTU for a number of years and felt that the management

respected their views. All of the staff we spoke with told us they enjoyed working at GUTU and felt it was a well led organisation. Staff also said that they all had a good working relationship with each other, but if they observed a member of staff doing something that they were not entirely happy with, they would have no hesitation in bringing it to their manager's attention.

Staff were asked for feedback. In October 2017 100% of staff who gave feedback felt valued and supported by their managers.

There were systems in place to check the staff training records to make sure staff training was up to date and staff were equipped to carry out their role and responsibilities and any training needed was booked.

Staff told us that the management team continued to encourage a culture of openness and transparency. Staff told us that the registered manager had an 'open door' policy, which meant that staff could speak to them if they wished to do so and worked as part of the team. Support was provided to the registered manager by the provider and senior management team in order to support the service and the staff.

The provider had clear values which was promoted by the management team to all staff. The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live as independently or with as little support as possible. Staff told us they felt part of the team and were able to contribute to meetings and share ideas for the benefit of the people using the service.

The management team met with staff in meetings. They discussed the operational effectiveness of the service and any issues or concerns arising with the service they were providing to people. The registered manager and provider, who was based at the office with the registered manager provided leadership in overseeing the service and provided support and guidance where needed.

The provider worked closely with social workers, referral officers, occupational therapists and other health professionals. The right support and equipment were secured promptly and helped people continue to live independently, safely or be referred to the most appropriate services for further advice and assistance.

We reviewed some of the registered provider's policies and procedures and saw these were updated on a regular basis to ensure they reflected current legislation. The policies and procedures were available for staff to read and staff were expected to read these as part of their training programme. Staff confirmed to us that they read the providers policies. The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had shared their last rating which was displayed in their office and displayed on their website.