MacIntyre Care

MacIntyre Hampshire and Kent Supported Living

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

The inspection took place over two days on 17 and 18 May 2017. The inspection was announced which means that we gave the provider 48 hours' notice of the inspection to ensure key staff were available to speak with us.

MacIntyre Care is a national charity providing support to people with learning disabilities. This service provided a personal care service to 25 people from a registered office in Totton Southampton. All of the people being supported by the service lived in their own home. Some people lived alone, whilst others lived in shared houses or supported living settings across Hampshire. The levels of support provided varied. Some received just a few hours support from an outreach service, whilst others received 24 hour care and had more complex health and social care needs.

The service did not have a registered manager. The previous registered manager had left the service in February 2017. A new manager had been appointed and was due to start in June 2017. 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 and associated Regulations about how the service is run. When in post the registered manager was supported by a number of front line managers, or heads of service, who had delegated day to day responsibility for managing the delivery of care within people's homes.

Recruitment practices needed to be more robust to ensure that all of the relevant checks were completed. Full employment histories had not been obtained for two staff members. This information has now been obtained. There were sufficient numbers of staff to meet people's needs.

Medicines were managed safely. Systems were in place to respond to and learn from medicines errors and medicines audits were undertaken to ensure medicines were being managed safely.

People told us they felt safe and there were systems and processes in place to protect them from harm. Care plans contained risk assessments and risk management plans.

Staff received a comprehensive induction which involved learning about the values of the service, the needs of people using the service and key policies and procedures. A comprehensive training programme was available and plans were in place to ensure that all staff refreshed their training in a timely manner.

Where necessary staff had undertaken mental capacity assessments to determine whether people could consent to the care and support being provided. Staff used a restrictions checklist to identify whether the care arrangements in place might in some cases amount to a deprivation of people's liberty in order to protect them from harm. Where this was the case, action had been taken to notify the Local Authority so that they could seek the relevant authorisations from the Court of Protection.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met.

People told us that the staff supporting them were kind and caring and helped them to live a busy and active life. Staff had a good knowledge and understanding of the people they were supporting. Staff were able to tell us about people's likes and dislikes which demonstrated they knew them well.

Care records were person centred and helped staff provide care which was in keeping with people's needs and wishes.

People were provided with opportunities to give feedback about the care and support they received. Complaints policies and procedures were in place.

Systems were in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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

Staffing levels were adequate and enabled the delivery of care and support in line with people's assessed needs. Action was being taken to ensure that all of the required recruitment checks were in place.

People told us they felt safe and there were systems and processes in place to protect them from harm. Care plans contained risk assessments and risk management plans.

Medicines were managed safely.

Is the service effective?

Good

The service was effective

Where necessary staff had undertaken mental capacity assessments to determine whether people could consent to the care and support being provided. Action had been taken to notify the Local Authority so that they could seek the relevant authorisations from the Court of Protection where there were restrictions on people's liberty to protect them from harm.

Staff received a comprehensive induction and a comprehensive training programme was available. Plans were in place to ensure that going forward all staff refreshed their training in a timely manner.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs. People received the support they needed to help them manage their healthcare needs.

Is the service caring?

Good

The service was caring.

Overall people were happy with the care provided and said they had good relationships with staff.

People told us that the staff supporting them were kind and caring and helped them to live a busy and active life. Staff had a good knowledge and understanding of the people they were supporting. Staff were able to tell us about people's likes and dislikes which demonstrated they knew them well.

Is the service responsive?

Good

The service was responsive

People's care and support plans were personalised and their preferences and choices were detailed throughout their care records. This supported staff to deliver responsive care.

People were supported to take part in a varied range of activities in line with their personal preferences and passions.

Complaints policies and procedures were in place and systems were in place to review these to identify trends or patterns so that further remedial actions might be taken.

Is the service well-led?

Good

The service was well led

The engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

MacIntyre Hampshire and Kent Supported Living

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.

The inspection took place over two days on 17 and 18 May 2017. The inspection was announced which means that we gave the provider 48 hours' notice of the inspection to ensure key staff were available to speak with us.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the first day, we visited the registered office and reviewed records and talked with the head of operations and other senior staff. On the second day we visited people who received support from the service in their own homes and spoke with two of them. We also spoke with people and staff on the telephone. Our expert by experience telephoned people and their relatives to gain their views about the care and support provided by the service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Many of the people using the service were unable to give us detailed feedback about the quality of their care

and so we spoke with their family members. Overall, we spoke with five people and six relatives. We also spoke with the head of operations and 13 other staff including front line managers, senior support workers and support workers. We reviewed the care records of three people in detail. We also viewed other records relating the management of the service such as staff files, rotas, audits and policies and procedures. Following the inspection, we sought feedback from five health and social professionals about the quality of care people received.

This is the first inspection of this service since it registered with the Care Quality Commission in June 2016.

Good

Is the service safe?

Our findings

People told us that being supported by the service made them feel safe. A person had sent the service a compliment which read, '[staff member] is very good at listening and understanding, I feel very comfortable and safe with her, they are very reliable and happy and bubbly, they are very good at explaining things I don't understand'. A relative told us, 'I think they are really well trained and know what they are doing. I have no concerns about safety when they are with him".

Registered persons are required to perform a range of checks to ensure that only suitable staff are employed to provide care and support to people. We were able to see that photographs of staff were in place, as were references. Checks had been carried out with the disclosure and barring service (DBS). DBS checks identify whether a staff member has a criminal record or is on an official list of people barred from working in roles where they may have contact with adults who may be vulnerable to harm from others. However, we found that in two of the four staff records viewed, there were gaps in their employment history. We spoke with the head of operations who took immediate action to ensure this information was obtained. We recommended to the head of operations that they review all staff records to assure themselves that all of the required checks are complete and satisfactory and they confirmed that they would do this.

Medicines were managed safely. Staff who administered medicines had completed training and underwent competency assessments. Medicines were kept safely in locked cabinets either in a central office or in people's own room. We reviewed three people's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines and did not contain any gaps or omissions. This provided reassurances that people were receiving their medicines as prescribed. There were basic protocols in place for the use of 'as required' or PRN medicines. We did note that the temperature of the areas where medicines were being stored was not being monitored in line with best practice guidance. Storing medicines within recommended temperatures is important as this ensures they are safe to use and remain effective. We discussed this with the management team who advised that they would explore options to address this. Systems were in place to respond to and learn from medicines errors and medicines audits were undertaken to ensure medicines were being managed safely.

People were supported to stay safe. People had specific risk assessments which considered the support the person might need to understand safeguarding issues and how to report a concern. Staff had received training in safeguarding adults and the organisation had appropriate policies and procedures in place. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Senior managers maintained a safeguarding log which served as a tracking tool, allowing them to document the actions taken at each stage of the concern. The log and a safeguarding group also supported the organisation to collate information about safeguarding concerns, monitor these for themes or trends, review lessons learnt and share learning about these across the organisation. The organisation produced 'The Safeguardian' newsletter each month which shared new information and ideas in relation to safeguarding. For example, the March 2017 newsletter had articles on keeping people safe online and safer medicines management. A staff member told us, "If I have a problem or any issue I raise it with my manager and head of service. I feel confident that any issue I have will be dealt with quickly, efficiently and resolved".

A social care professional told us, "The [frontline manager], has been good at reporting any concerns appropriately".

Checks were made to help ensure the safe management of people's money and staff maintained records of all expenditure. In some settings, recent audits had shown that the system of checks and management oversight needed to be more robust and recommendations were in place to address this. In some cases staff had completed a 'Me and My Money' assessment and undertaken workbooks with people, which helped to ensure that appropriate measures were in place to protect them from financial abuse, and to help them develop their ability to manage their money as independently as possible. The use of these was not fully embedded within the service and an action plan was in place to address this.

The service had a whistle-blowing policy line and subscribed to an independent charity, Public Concern at Work, which provide a confidential advice service for staff who may have concerns about poor practice within their work environment. Staff told us they were aware of the whistle-blowing policy and would use this to report concerns about poor practice. However, those we spoke with, were confident that the management team would act on any concerns they might have.

Each person had a risk analysis which identified the areas where specific risk assessments were required. Individual risk assessments were then prepared by key staff working with the person. Risk assessments covered a range of areas and included the person's finances, their health needs and risks arising from both their home environment and from being out and about in the community. Staff were well informed about each person's risks and the strategies in place to support them. For example, an agency worker was able to tell us about a person who was at risk of choking. They explained they had to ensure their food was cut up into small pieces and that they should not be left alone whilst eating. Some people could at times express themselves through displaying behaviours which challenged. Where this was the case, people had a positive behaviour support plan which focused on the proactive methods staff could use to avoid the triggers that could lead to the person presenting with behavioural challenges.

Staff were able to share with us examples of positive risk taking and there was evidence that staff did not restrict peoples interests, instead they were encouraged to try new things in stages, building up to more challenging activities or tasks. For example, staff told us how one person lived a very short distance from the day centre they attended, but had never gone to the centre alone. Staff waited until the person was ready to try this and then provided just the right amount of support to ensure this was achieved safely.

Staffing levels were adequate and we were advised that all of the commissioned support hours were being met and that staff had not missed any recent scheduled visits to people's homes. Staffing levels were determined by the commissioners of each person's care and support and were monitored by the service to ensure they were able to deliver effective care in line with the number of hours commissioned. Recruitment was on-going to ensure sufficient number of staff were available at all times. Where geographical areas presented particular recruitment challenges, the organisation was running campaigns to address this. Social media was being effectively utilised and staff could recommend a friend and were given a financial incentive for doing so if their friend was successful in their application. When necessary agency staff or relief care workers were used to fill gaps in the rotas. Where this was the case, the same agency workers were used so that people continued to receive their care and support from staff with whom they were familiar.

Staff told us that there were at times staff shortages, often due to sickness. Most felt, however that this was an improving picture. One staff member said, "I can say with conviction that although staff shortages seem to be a common thing in this sector, management go above and beyond in making sure that everyone gets the support they are entitled to". Another support worker said, "I've met some excellent support workers…

some exceptional, who work extra hours at short notice to make sure people are supported and to develop and improve the support we give". Staff told us that efforts continued to improve the continuity of care for people with the introduction of a four week fixed rota, for example. Staff were confident that these measures would bring further improvements.

Good

Is the service effective?

Our findings

Overall, people told us they were happy with the care provided. This was echoed by their relatives who also felt the service was effective. One relative said, "They look after [person] exceptionally well. He has very specific needs and can be a danger to himself and other people…but I'm impressed at how well they handle him". Another relative said, "I can't fault them. They are so important to the whole family. The care they give means that we can have a life without worrying".

Staff told us they felt the service delivered effective care and achieved positive outcomes for people. For example, we were told about one person who with the right support was now attending college and cookery classes and had become more confident in expressing their opinions. Another person had accepted their first eye test and at the age of 61 now had their first pair of glasses. Staff had effectively supported another person to develop their communication skills and enjoy a wider range of foods. This indicated that the support being provided was having positive outcomes for people. A staff member told us, "Without a shadow of doubt I can say that the service delivers on its promises". A social care professional told us, "The staff are engaging, helpful and I have had no concerns. [frontline manager] is always open and honest and helpful when undertaking reviews".

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

Most of the people using the service were able to give consent to everyday tasks, such as deciding what to wear or what they like to eat. Where this was the case, staff acted in accordance with their wishes. For example, during our inspection, we saw staff readily adapted their plans to respond to the changing wishes of one person. Where able, people had signed consent forms in their support plans for aspects of their care including, for photographs to be taken or for information to be shared. Where there was doubt as to whether a person was able to make more complex decisions about their care, staff had undertaken mental capacity assessments to determine whether people could consent to the care and support being provided. For example, the administration of their medicines and to the management of their finances. One of the people we visited had a mental capacity assessment to check they understood and agreed with the decisions to jointly fund new sofas for the lounge. However, in one of the locations we visited, some of the mental capacity assessments viewed were not clearly documented and contained inconsistencies which demonstrated that staff lacked confidence in applying the principles of the MCA 2005. We discussed our findings with the head of operations who advised that additional training would be arranged to develop the skills and knowledge of the relevant staff.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. In settings such as people's own homes or in supported living settings, depriving a person of their liberty can

only be authorised by the Court of Protection and applications need to be submitted by the local authority. Staff used a restrictions checklist to identify whether the care arrangements in place might in some cases amount to a deprivation of people's liberty in order to protect them from harm. Where this was the case, action had been taken to notify the Local Authority so that they could seek the relevant authorisations from the Court of Protection.

New staff completed MacIntyre's Person Development Portfolio (PDP). This included the required learning and development needed to obtain the Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. New staff undertook a period of shadowing and also learnt about the organisation's values, policies and procedures and the needs of people they would be supporting. Their probation period was successfully passed only when they had been assessed as performing their role safely and competently by their line manager.

Support workers were required to complete a range of 'Must do' training. This training was a mixture of e-learning and face to face training and included subjects such as first aid, food hygiene, safeguarding people, moving and handling and positive behaviour support. In addition, further training was identified relevant to each service which staff 'could' or 'should' do. This included training on subjects such as epilepsy and diabetes. The training programme available was extensive but not all staff completed this. We reviewed a training matrix which recorded which staff had completed the 'must do' training. This showed that not all staff were up to date with all of the required subjects. We spoke with the head of operations about this. They advised that there had recently been some changes within the organisation to the way in which training was recorded. This was still being embedded, but had led to some training not being refreshed on time. They have, since the inspection, sent us an action plan which confirmed the dates that staff have been booked on the required training. The plan also included the implementation of more robust measures to ensure that similar situations did not arise in the future.

The organisation had a team of Positive Behavioural Support (PBS) coaches whose role was to focus on supporting staff by delivering training, undertake observations and supporting more complex PBS assessments. The organisation had a clear positive behaviour support policy which focused on the use of proactive and preventative interventions to reduce behaviours of concern. Special interest groups were held in a number of subjects including autism, dementia, and positive behaviour support. The aim of the groups was for staff to share best practice, knowledge and skills and provide peer support. Some staff had been trained as 'Great Interventions' facilitators. Their role being to support staff through observation, feedback and role modelling to provide the best possible person centred care. Staff were generally positive about the training available and told us it helped them to perform their role effectively. One staff member said, "There are times when I ask my manager for training on a given subject and it is given to me". Another staff member said, "Macintyre have a comprehensive eLearning and face to face training (internal and external). Additional learning is encouraged and supported, I have completed an NVQ3 and additional courses including autism, care plan management, great interactions etc". Some staff felt that it could at times be difficult to prioritise training due to staffing issues and felt more could be done to provide cover.

Records showed that staff were not always receiving regular formal supervision. However, the head of operations told us that ad hoc supervision took place on a regular basis and all of the staff we spoke with felt well supported by their line managers and confident they could seek advice or support when needed. One staff member said, "I know that if I call up and say I need to discuss something, they are very approachable". Another staff member said, "I feel totally supported…[manager] is always on the end of the phone". We recommend however that the organisation ensure formal supervision is taking place on a more consistent basis as this is an important tool and helps ensure that staff and managers develop their skills

and understand their role and responsibilities. Some staff had received an annual appraisal but again not all. The appraisal process required staff to reflect upon how they worked in a manner in keeping with the organisations values and how well they supported people using the service.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. For example, one person had a detailed nutrition plan which included clear guidelines about how staff should support the person to avoid the risk of them choking on foods. People were encouraged to be involved in choosing and preparing their meals and shopping for their food. Where people shared their home with others, each person was supported to choose their own meals and eat to their own preferences.

Where necessary a range of healthcare professionals including GPs, dentists, opticians and speech and language therapists had been involved in planning peoples support to ensure their health care needs were met. For example, we saw that the GP had been consulted when one person declined to take their medicines. People had health action plans (HAP). A HAP holds information about an individual's health needs, the professionals who are involved to support those needs and hospital and other relevant appointments. People's health care needs were understood by the staff who were able to explain how they helped people maintain good health. For example, one care worker told us, "We try to improve their lives, [the person] has lost over a stone in weight and we are taking them swimming". Relatives also felt that staff supported their family members to stay fit and healthy. One relative said, "On Wednesday evening she goes to a Zumba class which is really important because she is overweight and diabetic and she needs to keep moving. The carers help to motivate her.' This helped to ensure that people's day to day healthcare needs were met.

Good

Is the service caring?

Our findings

Overall people told us they were happy with the care provided and said they were cared for by staff who were kind and caring. One person told us their care workers were "All kind and caring, I have a regular carer, I have got to know them well". In the 2016 annual questionnaire, 98% of people had said that their support staff were kind and friendly and made them feel good about themselves. A recent compliment read, 'I would like to thank MacIntyre for all the help I have had, all of the staff are friendly'. A relative told us, "Nobody involved has ever said no. They go the extra mile for him and we couldn't do without them. I would recommend this service to anybody who asked.''

Staff told us they were confident that the staff they worked alongside were kind and caring. One staff member said, "Yes, the staff at [location] bring different things to their support worker roles. We are an established team, we support people to be themselves and I think we are kind and caring and I have seen staff go beyond their role in times of crisis, for example, supporting someone who has lost a family member". Another staff member said, "Our clients are happy".

The organisation advocated a 'Great Interventions' approach. The aim of the approach was to ensure that staff placed people at the centre of their support and adopted a way of working which helped to ensure that the person remained in control of their lives. We saw examples of staff acting in a manner in keeping with this approach. For example, we observed staff interacting with people in a caring and meaningful way. The interactions were positive and cheerful and people appeared at ease with staff and were happy to join in conversations with them and chat about what they were doing. Staff respected people's decisions but were also motivating, encouraging them to make their own hot drink and change their bed linen.

Staff spoke fondly and with passion about the people they supported. For example, one staff member said, "We have four confident and happy individuals. [location] is their home and it reflects their personalities throughout. We receive great compliments from families and health professionals alike who say that it is a friendly and homely environment and not like some places they visit. I feel proud to be a part of that".

Staff showed they had a good knowledge and understanding of the people they were supporting. For example, staff told us how one person used a computer keyboard to tap out letters as a way of de-stressing and preventing behaviours which might challenge others. Staff were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat and what activities they enjoyed as well as their daily habits. This information was also reflected in people's care plans.

Information given to people was in an 'easy read' format which helped them to understand it and enhanced their ability to make informed choices and decisions. People had access to a 'service user guide'. This included information about the service, how many staff would be available to support them and house rules. The service user guide also explained that people could have the support of an independent advocate if they wished. This all helped to ensure that people were supported to be involved in making decisions about their care and support.

Staff took the time to determine what people wanted and gave them the opportunity to make choices. Staff supported one person to use an application on their tablet to make choices about and plan their meals for the week. A relative told us how staff had respected their family member's choice not to have a support visit in the evenings to help prepare a meal. They told us, "[person] refused to have an evening call and they totally respected that so they leave her a meal in the microwave with a big sticker on the front showing her what to do in pictures because she can't read".

People were involved in planning their care. For example, we saw that one person was supported to plan his week and choose which member of staff he would like to accompany him on activities. Staff had worked with one person to develop their positive behavioural support plan using imagery and references from Dr Who which they were able to understand and relate to. Staff were also planning to make an audio recording of another person's care plan so that they could listen to this. All of the relatives we spoke with told us they felt involved in their relatives care.

Where people wanted this, they were supported to develop their friendships with their housemates and maintain their relationships with their families. During our inspection, we saw that a family member was visiting one house to support with maintaining the garden. A staff member told us, "They [people] can freely go and see their family members and they live with their friends, it's real life".

There was evidence that staff advocated for people, where appropriate, who were at risk of having their commissioned hours of support reduced. Staff understood the effect this had on people's wellbeing and tried wherever possible to alleviate the impact of this, although this was not always possible and in all cases the level of support being provided was not the organisation's decision but that of local commissioners.

Staff spoke to us about how important it was to protect people's privacy and dignity and this was reflected in people's care plans. For example, we saw that staff were reminded of the importance of ensuring blinds were pulled and curtains closed when people were preparing for bed. We observed that staff knocked on people's doors before entering their rooms and asked their permission for our inspector to check their medicines and financial records.

Whilst not everyone had this, we saw some examples of personalised end of life care plans which described how people would like their care to be managed in their final days.

Good

Is the service responsive?

Our findings

People's care and support plans were personalised and their preferences and choices were detailed throughout their care records. This helped to ensure their care remained meaningful and supported staff to deliver responsive care. People's care plans included a 'one page profile' that described, 'what people admire about me', 'what's important to me' and 'how best to support me'. For example, one person's one page profile described how they 'lived for the moment' and valued being given clear time lines and having set routines as part of their support. Information was available about the support people needed with decision making and how this supported them to maintain choice and control over their support and daily lives. Care plans included information about the key attributes people wanted their staff to display, for example we saw that one person wanted their staff to be 'proactive', 'enabling' and 'have a can do attitude'.

Communication plans described the individualised ways in which people communicated and included hints for staff to aid positive communication. Guidance was available about the support people needed with eating and drinking and managing their medicines and the activities they liked to take part in. Where people displayed behaviours or concern or which might challenge others, positive behavioural support (PBS) plans were in place. These included a description of the behaviours, information about the triggers, and guidance about how to respond such as using distraction techniques. Overall the supports we viewed appeared to be accurate and mostly up to date. In some settings staff told us that care plans were being reviewed and updated as they had recently taken over the provision of the case from another provider. This was helping to ensure that the plans more accurately reflected the support now being provided. Staff told us they could refer to people's care plans in order to understand their needs and it was evident that the care plans had been read by staff. This helped to ensure staff understood the needs of the people they supported.

Staff maintained detailed daily records which noted how the person had been and any outings or activities they had been involved in. The records included information about what the person had eaten and whether they had undertaken any domestic tasks. Charts were used to record any incidents of behaviour which might challenge others and diaries used to record the frequency of another person's seizures. The daily records and our observations indicated staff were following guidance in the support plans and were encouraging people to direct their own care whenever they were able.

People had monthly meetings with their support team to consider their accomplishments and what had worked well that month before agreeing goals or objectives for the coming month. These meetings helped to ensure people's daily support remained relevant and purposeful. Relatives said they were kept informed about any changes to their family member's health or wellbeing.

More formal person centred reviews took place intermittently and people, their family and relevant professionals were asked to give their views and feedback about the care and support they received. People's views and aspirations were used to agree new goals and objectives and their support plans were updated to reflect these. We saw a number of examples where the person's goals from the previous year had been achieved. For example, one person had been supported to get a new blue carpet for their room.

People regularly took part in a range of activities based on their own interests. This included arts and crafts, trampolining, day services and dance groups. People were supported to develop their independent living skills, such as cooking, shopping and cleaning. A relative told us, "They are very good, they take [person] out into town shopping". People were supported to try new activities. For example, staff supported a person to try swimming. This was a great success. A staff member told us, "They now go weekly, its quite special for him, he loves it". Another person had joined a crocheting group with staff support and had been able to use their needlework to make blankets to give as gifts at Christmas. Staff supported another person to achieve an ambition from their 'wish list' which was to attend a course at a local college. Despite their anxieties, with the right amount of support the person was able to attend the course and enjoy it. Staff had written an article for the MacIntyre Newsletter describing how proud they were of the person for achieving this. In the supported living settings we visited, we saw lots of photos of people enjoying activities, trips both alone and with their flat mates which helped to foster positive relationships within the home they all shared.

Complaints policies and procedures were in place and were available in easy read formats. Information about how to raise a concern or make a complaint was available within the service user guide. We looked at the complaints made so far in 2017, and saw there was evidence that these had either been investigated or were in the process of being investigated. We did note that the complaint records did not always provide a comprehensive account of all of the actions taken in response, but staff were able to provide further information about this. The outcome of complaints was monitored via a complaints tracker. The organisation had oversight of the tracker which also served to identify trends or areas of risk that needed to be addressed. People and relatives told us they had were confident that they could raise concerns or complaints and that these would be dealt with.

Good

Is the service well-led?

Our findings

The service did not currently have a registered manager, although a new manager had been appointed and was due to start in June 2017. In the meantime, the service was being led by a head of operations who was based at the service. The leadership structure within the service included front line managers and heads of service supported by senior support workers. Staff were positive about all of this wider leadership team. Staff comments included, "My manager supports me well and is always on hand for the staff at [location]" and "I have a brilliant manager, they are up to scratch". An agency worker told us, "I enjoy it here, its one of the better places I have experienced... it is well run". A relative told us, "They do try so hard to be accommodating and are very sympathetic and understanding".

The engagement and involvement of people was encouraged and their feedback was used to drive improvements. Annual surveys were completed, the responses were analysed and an action plan drafted to address any areas for improvement. People's feedback from the last survey in 2016 were largely positive with 96% of people saying staff kept them safe and 93% of people saying their support was either good or very good. People's responses indicated that they felt the organisation could be better at involving people in choosing new staff and in involving them in reviews of their care plans. To address this an action plan had been developed.

Staff feedback was also valued. Staff meetings were held on a regular basis and were an opportunity to discuss issues affecting the people being supported. A manager told us, "I ask their [staff] opinion, its all-inclusive, we have the same goal". The organisation had a staff council which provided a forum for staff to comment on and contribute to the development of the service. The staff we spoke with clearly enjoyed their work and told us that they received regular support from their managers and that morale amongst the staff team was good. Some staff did express concerns about the turnover of staff and about communication not always being effective or timely. Most however felt this was an improving picture. One staff member said, "I believe that the service is making inroads after a turbulent time. I believe that management are now making an effort in the way they communicate information to us". Other staff felt that the introduction of staff newsletters had helped with communication.

Systems were in place to monitor the safety and quality of the service provided. Great interventions audits were undertaken and assessed how staff were facilitating meaningful communication and working with people in a manner that helped them to feel valued. Where these audits had identified that improvements could be made to help improve interactions, an action plan with clear time scales had been developed to support this which included repeating key training. Recent audits had been undertaken in relation to how people's finances and medicines were being managed. A number of improvements had been identified and an action plan was also in place to address these. Each of the locations where people were being supported were overseen by a frontline manager who submitted monthly reports. These would normally be submitted to the registered manager and reported on issues such as recruitment, training, people's support and wellbeing and the completion of monthly quality checks. In the interim these reports were being reviewed by the head of operations and enabled them to retain oversight of issue across the service. The front line managers also intermittently undertook spot checks. Those viewed were detailed and indicated people

were receiving effective support. The organisation had systems in place to review the effectiveness of its PBS policy and the implementation of this. Incidents involving behaviours of concerns were reviewed and investigated to achieve organisational learning. Managers meetings were held every two weeks and were used as an opportunity to review matters such as recruitment, health and safety and staffing matters.

In the supported living locations, staff completed some health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering care. Many of the issues identified remained the responsibility of the landlords who provided the accommodation people lived in. There was evidence that staff were liaising with landlords to ensure issues were rectified. Where health and safety incidents had taken place across the organisation, the findings from these were developed into pictorial guides to share learning and prevent similar events from happening again. Each person had a personal emergency evacuation plan (PEEPS) which detailed the assistance they would require for safe evacuation of their home. The organisation had also developed a business continuity plan which set out the procedures for dealing with foreseeable emergencies such as a person going missing or a reduction in staff numbers due to widespread illness.

The head of operations had a good understanding of the challenges facing the service and the areas where improvement or developments were needed. They explained that one of the main challenges at present was achieving full recruitment so that people had consistent support. Work was also continuing with commissioners of people's care to ensure this remained at the right level despite challenges with social care funding. They were positive that the new manager starting in June would continue to drive improvements within the service and ensure that people continued to receive an effective and responsive service. Overall the people and relatives we spoke with felt they were receiving a good service, would happily recommend the service and struggled to identity areas where they felt the service could improve. This was summed up in the words of one relative who told us, "There are no problems at all. I would recommend them to anybody. I hope nothing gets changed because that's my only fear to be honest".