PossAbilities C.I.C

Grenfell House

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

This inspection of Grenfell House took place on 1 & 2 February 2018. This was the first inspection of the service which began operating from its current location in 2016. We gave the provider 48 hours' notice of our inspection because the service delivers personal care to people living in a supported living setting and we wanted to be sure the registered manager and people who used the service would be available to answer our questions during the inspection.

The inspection was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise in caring for someone with a learning disability.

There was a registered manager in post. 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.

Grenfell House is run by PossAbilities, a social enterprise designed to help individuals with mental health difficulties, learning and physical disabilities live the life they choose. This service provides care and support to people with learning disabilities and mental health needs in 25 'supported living' settings within Halton, so that they can live in their own home 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. We conducted our site visit at Grenfell House which is the registered office; however, we also visited two of the properties in which people lived during our inspection. At the time of our inspection, the service was providing support to 74 people.

People told us they felt safe when being supported by the Grenfell House staff.

Risks to people's health, safety and welfare were assessed and detailed information was available to guide staff on how to support people to stay safe, whilst promoting their independence as far as possible. Bespoke Positive Behaviour Support plans were in place for those people who displayed challenging behaviour. These plans were comprehensive and enabled staff to understand people's behaviour and how best to manage this for the safety of the individual and others.

Medication was managed safely and administered by staff who were appropriately trained. Support plans were in place regarding PRN (as needed) medication. The registered manager had addressed previous issues in relation to the recording of medications and implemented further training and development for staff in response.

Staff recruitment procedures were robust and ensured that staff appointed were suitable to work with vulnerable people.

There were appropriate numbers of staff deployed to meet people's needs and to ensure people received consistent support. Staff we spoke with were able to describe the course of action they would take if they felt someone was being harmed or abused, and understood the reporting procedures.

Accidents and incidents were recorded and reviewed and the registered manager had implemented changes to the service after reviewing the findings of safeguarding investigations. We saw evidence that 'lessons learned' were regularly incorporated into the on-going learning and development of the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service operated within the principles of the Mental Capacity Act 2005 (MCA). Records demonstrated that processes were in place to assess people's capacity and make decisions in their best interests with a focus on the least restrictive option.

Staff were assisted in their role through induction, training and supervisions and staff told us they felt well supported in their role. The Care Certificate was undertaken by newly recruited staff. Staff were also trained in specialist subjects such as epilepsy, autism and positive behaviour support to help their understanding when supporting people with these needs.

Staff supported people to maintain their health and well-being. Staff devised health action plans for people in consultation with people's relatives. The service maintained good links with community health partners to ensure people's health needs were met.

People told us they liked the staff who supported them. One person commented, "They are nice to me, they speak nice and help me if I am upset, they are never unkind." Staff had developed strong relationships with the people they supported and had a good understanding of people's individual communication needs and this enabled people to be involved in decisions about their day.

Staff we spoke with were able to describe how they protected people's dignity and right to choose how they wanted their care delivered. The service held 'Dignity Days' to promote dignity within the service and considered what dignity meant to the people they supported. There were relevant policies and procedures in place around confidentiality, data protection and equality and diversity to support good practice.

Care plans contained a high level of person centred information. Person centred means based on the needs of the person and not the service. Each care plan provided detailed information regarding people's individual likes and dislikes and how they wanted their care delivered. This level of detail enabled staff to get to know the people they supported.

People were consulted in relation to the staff team that supported them. People and their relatives were involved in the recruitment and selection process of new staff and exercised choice in respect of who delivered their care.

People had access to an easy read complaints procedure and complaints were dealt with appropriately and in accordance with the registered provider's policy. People and their relatives felt confident in raising concerns and they would be listened to. Opportunities were available for people to provide feedback regarding the service through the use of questionnaires, family forums and service user advisory board meetings. The registered provider had plans for the further development of these systems to include the implementation of 'quality checkers' and family advisory groups.

Staff supported people to access the local community and to engage with activities of their choice. People spoke enthusiastically about the range of individual activities they engaged with such as theatre trips, theme park visits and holidays. Staff were responsive to people's changing needs and told us that activity plans could be changed to reflect the well-being or wishes of the individuals.

Staff spoke positively about working for the organisation and the registered manager who they described as 'hands on', 'approachable' and 'a fountain of knowledge'. Staff we spoke with were able to describe the visions and values of the service, and felt supported by registered manager and registered provider in delivering them. The organisation had employee recognition schemes in place to acknowledge and celebrate good practice within the organisation.

The registered manager had a number of different systems in place to assess and monitor the quality of the service, ensuring that people were receiving safe, compassionate and effective care. The organisation's governance framework ensured that audits were completed on a regular basis with a focus on continued improvement. This included quality assurance checks at registered provider level.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding the service.

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 and their relatives felt safe with the care provided by staff at Grenfell House.

Risks to people's health, safety and wellbeing were assessed and managed in a manner that promoted both independence and safety.

Staff had received safeguarding training and understood how to recognise abuse and the reporting procedures. Safeguarding issues, accidents and incidents were documented and appropriate action was taken in response.

Medication was safely managed at the service and on-going improvement was planned to further strengthen these processes.

Is the service effective?

Good

The service was effective.

People and their relatives told us that staff knew them well and were effective in meeting their needs.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. People's choice was promoted and consent was sought before providing care.

Staff had a good understanding of people's individual care needs and were supported through supervision, appraisal and on-going training.

Staff worked with a range of health and social care professionals to ensure people received the support they needed. Health action plans were developed for each person using the service.

Is the service caring?

Good

The service was caring.

Interactions between staff and people using the service were warm and familiar. People told us they liked the staff who supported them and that staff treated them with respect.

People were included in decisions about their care and support. Relevant policies were available in easy read formants to promote people's participation and involvement in their care.

Staff encouraged people to develop their daily life skills with a focus on empowerment.

People's personal and confidential information was kept secure and people's privacy was respected.

Is the service responsive?

Good

The service was responsive.

Care plans contained a high level of person centred information and outlined people's preferences, wishes, likes, and dislikes.

People and where appropriate, their relatives, were involved in the assessment and planning of their care and support.

People were assisted to access the local community and supported to engage in a range of activities, hobbies and interests that were tailored to their needs.

A process for managing complaints was in place and complaints were dealt with in accordance with the registered provider's policy.

Is the service well-led?

Good

The service was well-led.

People and their relatives spoke positively about the registered manager, the service in general and the organisation of their support packages.

Governance systems and processes were in place to assess, monitor and improve the safety and quality of the service. We saw that there was a culture of continuous improvement within the organisation.

There was a process in place to gather and analyse the views of people in the form of annual surveys, family forum, tenant and service user board meetings.

Staff told us there was an open culture within the service and they felt confident to speak with the registered management if they had a concern.	

Grenfell House

Detailed findings

Background to this inspection

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

This inspection took place on 1 & 2 February 2018. We gave the registered provider 48 hours' notice of our inspection. This is because the service delivers personal care to people living in a supported living setting and we wanted to be sure the registered manager and people who used the service would be available to answer our questions during the inspection.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case, the care of someone who had a learning disability.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. We were not made aware of any concerns about the care and support people received. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. We used all of this information to plan how the inspection should be conducted.

As part of the inspection we visited the office and met with the registered manager and nominated individual for the service. We spoke to three members of office staff including two team leaders and a senior officer. We spoke to four members of care staff. We spoke with 12 people who used the service and five relatives. We visited a further two people in their own homes with their permission. We also looked at seven care plans for people who used the service, MAR's for five people, six staff personnel files, staff training and development records as well as information about the management and governance of the service.

Good

Is the service safe?

Our findings

People told us they felt safe when being cared for by staff at the service. Comments included; "Yes, I do feel safe because it's my own [home] and I feel secure because there are staff on site" and "Yes, they keep me safe, [I] speak to [staff member] if I am worried about anything." People's relatives also told us they felt reassured that their relative was safe. Comments included; "[Relative] is absolutely safe, I do not have to worry, staff know how to deal with them" and "I do indeed [think relative is safe], they have mobility issues and had a few falls recently, staff are on the ball."

We reviewed positive behaviour support plans for people who presented with complex behaviours and saw these provided detailed information to staff about how to manage challenging situations for the safety of both the individual and staff. The plans provided information on the context of the behaviour, what the person might be trying to express through their behaviour, for example, 'person is getting anxious' and signs of escalating behaviour. Each person who displayed challenging behaviour had a dedicated staff team who attended bespoke annual training workshops which considered the background of the person, factors influencing their behaviour, functions and meaning of the behaviour for that individual and management strategies.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. These were completed in a variety of areas such as, safety in the community, financial abuse, medication, smoking, infection and falls. These assessments considered the hazard, the controls in place to mitigate the risk and action to be taken to minimise the risk. For example, one person was at risk of financial abuse and we saw that a range of preventative measures were in place. This included purchase request forms and record of conversations to show evidence of consultation with the person regarding how they chose to spend their money before decisions of expenditure were made.

People told us they got their medication when they needed it. Comments included, "[Medication] is OK, I get it when I need it. I have a pill to calm me down sometimes and this helps me" and "Medicine is all OK." One person's relative told us, "Medication is delivered in a nice quiet place so if [relative] becomes distressed, they can keep their dignity and privacy."

Medication systems and processes ensured that medicines were being safely managed. Staff were appropriately trained to administer medication and had bi-annual reviews of their knowledge, skills and competencies relating to managing and administering medicines. The service had previously identified errors in respect of the recording of medication. In response to individual staff errors, the registered provider implemented up to three observations with the relevant member of staff to check their capabilities before being signed off to administer medications again. Furthermore, personal development plans had been implemented for senior staff to promote more robust oversight of medication and these objectives were checked monthly.

We reviewed the medication administration records (MARs) for five people and saw these were completely accurately. Medication quantity checks were completed at each handover by staff. There were records in

place to track whether people had been administered topical preparations (creams) and body maps which recorded the areas of the body the cream was to be applied to.

We saw that medication was stored safely and securely within the individual supported living properties. A staff signature list was completed so that all signatures on MAR's were identifiable. We saw personalised PRN (as needed medication) plans in place to ensure an individual approach to medication management. One person required PRN medication before health appointments. Records stipulated that management were to authorise this prior to any medication being administered to promote safe use. Another plan outlined that PRN medication to help calm the person should not be administered unless other techniques were tried first such as offering the person their favourite game or distraction techniques. Each protocol was signed by staff to demonstrate they had read and understood.

Each person's care record contained a medication pen picture which contained information on their diagnosis, allergies, medication prescribed and the reasons for this. Additionally a medication support plan provided staff with information regarding the ordering and storing of medication and what action to take if prescribed medication was not taken. Actions plans were in place around specific needs such as epilepsy and actions to take in the event of a seizure.

Prior to our inspection, we reviewed the number of different incidents which occurred at the service; this included the number of referrals made to safeguard people's welfare. We saw that a significant proportion of incidents involved agency members of staff. We saw that the service had responded and taken action to recruit permanent members of staff through ongoing recruitment. Where incidents had been substantiated, action plans were drawn up and remedial action was taken to prevent the risk of reoccurrence. For example, one incident involved missed medication. The service recognised that medication handovers were not completed consistently and as a result, an action was for medication workshops to be rolled out across the service to develop staff knowledge and skills relating to the administration of medication.

Training records showed and staff confirmed that safeguarding training had been provided to both staff and people who used the service. Staff we spoke with were also able to explain the procedures and what course of action they would take to address actual or potential harm if they felt someone at the service was being abused. Staff understood the whistle blowing procedure (the reporting of unsafe and/or poor practice without fear of reprisals). Having a whistle blowing policy helped to promote an open and reflective culture within a service.

People told us there were sufficient numbers of staff to support people safely. Comments included; "Yes, I have more than enough staff" and "Yes, they have time to chat and they do what they are supposed to do."

The service employed approximately 140 permanent staff and 12 relief members of staff. We reviewed a sample of staff rotas and saw that there were sufficient numbers of staff rostered to support people effectively. The registered provider told us how they had strived to ensure a reliable and consistent staff team. In response to concerns they had identified regarding agency staff they had ceased their use of unfamiliar agency staff in all but one property since October 2017. The service had approximately 7 staff vacancies at present.

We checked how staff were recruited at Grenfell House and the processes followed to ensure staff were suitable to work with vulnerable people. We reviewed six personnel files of staff who worked at the service and saw that there were safe recruitment processes in place including; photo identification, references from previous employment and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that prospective staff are suitable to work with vulnerable adults. One staff member appointed had a

historical offence history and we saw that appropriate action had been taken to assess the implications of this and any potential risk they posed.

Staff supported people to be safe in their own properties. People had Personal Emergency Evacuation Plans (commonly known as PEEPs) which were personalised and reviewed regularly, to support evacuation in the event of an emergency. These contained important information on the person's mobility needs. We spoke to a team leader who told us and saw certificates within files which confirmed that staff had delivered a fire safety workshop to people to educate them about fire safety in their home. An easy read policy entitled 'Make your home safe' was also circulated as part of the training.

Records relating to stoma care guidance highlighted the need to wear PPE when supporting the person. Staff had access to personal protective equipment (PPE) and essential hygiene tools such as gloves, aprons and antiseptic gel to promote good infection control practices.

Good

Is the service effective?

Our findings

People and their relatives told us that staff knew them and were effective in meeting their needs. Comments included; "They do a good job", "They give me support as and when I need it, they are always willing to help" and "They are very professional and understand my needs." People's relatives commented, "They manage [relative's] epilepsy well and stick to procedures", "They have regular training, staff are very good", "They cope well [with relative's challenging behaviours] and calm [relative] down." Staff we spoke with could explain individual care plans, specific risk assessments and complex behaviours and what support needed to be provided to ensure people received effective outcomes.

The service ensured that all newly appointed staff were assessed in line with the Care Certificate (CC). The care certificate is a nationally recognised set of fifteen standards that care staff are expected to meet as part of their role. The CC requires that staff complete a programme of training, be observed in practice and then signed-off as competent by a senior colleague. New members of staff also had a six month probation period with monthly reviews before being appointed permanently.

We reviewed the staff training matrix and certificates within staff recruitment files which showed staff received training in areas such as moving and positioning, dementia awareness, adult basic life support, person centred approaches and mental capacity. Some staff also had more specialist training in topics such as autism, epilepsy, stoma care, and positive behaviour support training to meet the specific needs of individuals. The service appointed 'champions' in specific topic areas who had received more in depth 'train the trainer' training in areas such as safeguarding, positive behaviour management, acquired brain injury and moving and positioning. We spoke to the positive behaviour management champion who explained their role was to deliver training to other staff members in the form of workshops and were a 'point of contact' for any queries regarding management of challenging behaviour. The training programme ensured that staff had the skills and knowledge to support people safely.

We reviewed the staff rotas which showed only staff who had the necessary skills were deployed to support specific people. For example, all staff deployed to support a person with epilepsy had undergone additional training to administer anti-seizure medication.

The registered provider's records showed some staff required refresher training in some topics and we reviewed the upcoming training planner which showed this was scheduled. The majority of training delivered by the service was face-to-face training and the staff told us they found this effective. Staff also told us they felt able to request further training when needed. One staff member commented; "We can always go to manager if we need any additional [training]."

Staff told us they received regular supervision and an annual appraisal and the registered provider's records evidenced this. Supervision sessions between care staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Records showed that direct care observations were completed every six months to check whether staff continued to deliver quality care.

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

Mental capacity assessments were undertaken and were decision specific in accordance with the principles of the MCA. For example, one person had expressed the wish to have their own bank account. Staff had undertaken a detailed assessment of the person's ability to manage money, recognise denominations and understand how to withdraw money using visual tools which depicted pictures of high street banks before arriving at a decision. The rationale for the assessor's decision was clear and detailed.

The registered provider's records showed there was a focus on the least restrictive intervention throughout the service. Staff completed assessments to consider whether restrictions were in place and whether these restrictions amounted to a deprivation of liberty for the person. For example, where tenants had locks on doors, window restrictors or where they used a wheelchair belt. If a restrictive practice was identified staff liaised with the relevant social care professionals to address this and ensure the appropriate legal authorisations were in place. The registered provider held deprivation of liberty discussion groups whereby staff could discuss individual cases in confidence and seek advice regarding the use of restrictive practices.

People were consulted with regards to their care and support needs. People told us, "[Staff] always just ask what I want to do, they tell me when they are doing things." A person's relative told us "All care is delivered with permission and agreement." People signed their own consent documents were able in respect of decisions such as permission for photos to be taken, access to their home, personal care and medication administration. If people were not able to sign their own care files, a best interest decision was made on their behalf and relevant family members were consulted.

Staff supported people to access health appointments and worked closely with professionals such as the community matron to support people using the service when attending appointments. For example, staff had worked closely with the community matron to develop a procedure for supporting people when having venepuncture procedures. This involved consultation with the positive behaviour management team as to the least restrictive options of holding the person with a focus on respecting the person's personal space and giving control back as soon as practically possible. A risk assessment was completed prior to and after each venepuncture and a debrief was held to reflect on what could be done differently during the process.

People had health action plans within care files which were reviewed quarterly. These plans outlined actions to be completed to ensure people's health needs were met, by who and by when. The plans we reviewed detailed any upcoming appointments with opticians, speech and language therapy, medication or health reviews. Staff told us they consulted with their local community partners in respect of the frequency of health checks.

We saw that each person's care plan contained a health passport which contained a range of important information relevant to the individual such as their support needs, details of other professionals involved in their care, medical history and treatment plan. These plans provided a succinct summary that was easily accessible in the event that someone had to be admitted to hospital or transfer services in an emergency.

People were supported with their nutrition and hydration needs if required. We saw that food and nutrition diaries were held within people's supported living properties for those people who required them and

menus were displayed in people's home. Staff told us people were assisted with food shopping but chose what they wanted to eat with staff encouragement to buy healthy options. One person told us, "I go food shopping to Aldi; [staff member] helps me with my shopping list."

We saw that food and fluid pen pictures provided guidance to staff on how people needed to be supported with their nutritional needs and information on specialist diets was recorded with care files for example, those who required thickened fluids. One person was identified as being at risk of choking. Staff were directed to supervise at all times during meals and encourage the person to remain seated for a short period after meals. The guidance provided by the relevant health professionals was included within the care file and this was reflected in the eating and drinking risk assessment.

Good

Is the service caring?

Our findings

People spoke positively about the staff that supported them. Comments included; "All the staff are friendly and very professional. What I like about them is you can have a laugh with them as well", "Carers are my family, they are kind" and "I think they are nice and kind, they help me wash my hair." People's relatives also agreed that staff were caring and respectful. One relative commented; "They are loving, like a family, they know her inside and out, her likes and dislikes, she is treated as an individual like it's her own home."

Staff also spoke fondly about the people they supported. One staff member told us they had supported the same person for 14 years and knew the person very well. Another staff member told us, "[Person] doesn't look at me like a manager, they look at me like a family member, and we have a friendship."

People told us that staff provided emotional support when needed. One person told us they worried about their family member and staff supported them with this. Another person told us that staff responded appropriately when they got upset, "[Staff member] will give me a hug I feel much better then."

We observed and were told that staff encouraged people living in the supported living properties to do as much for themselves as possible. People told us, "[Staff] encourage everyone in that building to be as independent as they can be" and "Yes, I have become more independent."

Care plans focused on the ethos of empowerment and staff followed the principles of 'Active Support' with the aim of encouraging people to develop their daily living skills and independence. Care files reminded staff of the importance of promoting independence, for example, '[Person] will take their own laundry to the utility room' and 'When out shopping [person] pushes their own trolley and makes own choice of what food they would like'.

One staff member provided an example of how staff promoted independence in their everyday interventions with people. The staff member explained; "One person used to spill their cereal when they tried to pour it themselves as they were unable to measure it properly; now the support worker will measure out the right amount of cereal and place it in individual sandwich bags so the person can pour it in themselves in the morning and can do breakfast independently."

We reviewed the registered provider's records which showed this good practice had been noted by other professionals within the compliments record. One written compliment praised staff approach and outlined, "People who lived there carried out all tasks independently unless support was needed."

People's religious and identity needs were respected and people's privacy and dignity needs were promoted throughout the service. Staff supported one person to attend an annual lesbian, gay, bisexual, and transgender pride festival and another person to attend church weekly. A dignity day was held during our inspection whereby people were invited to attend to discuss what dignity meant to them. This was the first event of this kind but the registered manager told us of they had plans to roll this out on a more frequent basis.

People were actively involved in making decisions about their care and support and it was evident that they had input into their care plans because their wishes and preferences were recorded and care plans were decorated in themes of interest to them such as Dr Who and Mr Tumble according to individual preferences. Care plans were in an accessible format and pictures were used to promote people's engagement where required. Care files contained a one page profile regarding important relationships to people and their support needs. This enabled staff to understand the background of the person and promoted rapport building between staff and the people they support.

Care records were written in a caring and positive manner. For example, each care plan contained a document entitled; 'What people like and admire about me' which outlined positive things people had said about the person such as; 'A lovely smile' and 'A good sense of humour.' People's communication needs were also recorded within care files so that staff could converse effectively with the person. One file reminded staff to adapt their communication and speak slowly so that the person could understand. Another care file outlined that the person was unable to verbally express themselves but enjoyed making clicking noises with their mouth and liked staff to join in and do this back.

People's advocates and Independent Mental Capacity Advocates (IMCAS) were clearly recorded within files. IMCAs represent people where there is no one independent, such as a family member or friend to represent them.

People's personal and confidential information was kept secure in the office and computers were password protected. Staff understood the principles of confidentiality and had received training in data protection.

Good

Is the service responsive?

Our findings

Staff told us the ethos of the service was a focus on person centred care. We reviewed records which showed that staff were asked to reflect on their approach and self-assess how person centred they were through the use of questionnaires. The care files we viewed reflected this approach and contained a high level of person centred information. The level of detail contained within care files enabled staff to appreciate and understand the level of care and support that needed to be provided and in what ways to suit the needs of the person. For example, one person contained very specific step by step instructions regarding a person's medication routine. This information was important to understand how to support the person effectively because any departure from the person's specific routine caused great upset for the individual.

Information contained in people's positive behaviour support plans was centred around the individual needs of the person. Information contained within the support plans allowed staff to identify in what circumstances behaviours were more likely to occur. This included certain environments or situations that the person found particularly difficult. We saw that efforts were made to predict behaviour and staff were reminded to consider pro-active strategies to minimise the chance of this developing. By pro-active we mean what the person and staff can do before any behaviour that challenges presents, to help prevent it or meet the person's needs differently. Plans also detailed how people and staff can worked together in the best possible way to make these known situations easier, to help keep people and their team safe. For example, one person became distressed if any staff member sat in a particular chair in their home. Care files contained detailed information and a picture of the relevant chair to alert any unfamiliar staff to this preference so as to not trigger behaviours .

People had bi-annual reviews of their care plan or when their needs changed. People were prompted to consider 'Good things that have happened recently', 'What's important to me', 'What's working' and 'What's not working'. We saw that the person, their family and staff were all involved in the reviews and able to give their own perspective in respect of the above questions. People told us, "I have 1-1 meetings and I can tell them where they are going wrong and they listen" and "Problems are sorted." People's relatives also told us they felt consulted and informed of any changes to their loved ones care. One relative told us; "We have a close working relationship."

Care records showed individual plans around the many different aspects of care which staff needed to be familiar with such as behaviour management, health and medication and the way in which people wanted their support delivered. We reviewed a selection of essential lifestyle plans contained on the electronic system. These contained detailed information on people's social history, relationships, special events and religious needs. Staff used these documents as 'live documents' and updated these when people's needs or preferences changed. This information enabled staff to get to know people and deliver personalised care that was responsive to their changing needs.

People were actively involved in making decisions about who supported them by being consulted with regards to the staff selection and recruitment process. People were asked as to whether they required a gender specific carer and pictorial tools were used to engage people in this process. Job applications were

designed in conjunction with the person and their family and contained pre-requisites identified by the person such as 'the ability to laugh at my jokes' and 'experienced with autism'. Matching profiles were completed by both staff and people using the service to match staff with people with similar interests.

People were supported to access the community and engage with activities of their choice such as arts and crafts, gardening, attending the theatre, exercise classes and attendance at day centres. People told us, "I pick what I want to do and they take me, I've recently been to a tribute concert", "I am going to a disco tonight" and "I am going to the cinema today to see Early Man." One person's relative told us; "One carer really stood out she helped [relative] make a nativity scene. [Relative] was really thrilled with it and so was I."

One person was supported to continue their job which involved litter picking in the local park with staff. Activity planners were displayed within people's supported living accommodation but staff told us this was flexible depending on people's wishes and preferences. We saw that another person had been supported to go on holiday with staff. We noted that extensive consultation and planning was held prior to the holiday which included a 'My holiday' planning meeting to discuss financial outlay, destination, transport and activities. Staff had completed the relevant risk assessments to assess how the person would be kept safe in different surroundings. An easily accessible 'holiday' file' was developed which contained all essential information relevant to the person.

People and their relatives felt confident in raising any issues about the service they received and felt they would be listened to. One person told us; "They help out when I need them to, any issues I can come and speak to them, if they're busy, they will put time aside." One person's relative told us they had to raise a concern on one occasion; "It was logged and was resolved well."

The registered provider had processes in place to receive and act on complaints. People told us they would speak with the manager if they had any concerns or complaints. An easy read complaints policy was on display in people's home for people to access if they required it. We reviewed a sample of recent complaints from people using the service and saw these were dealt with in accordance with the registered provider's policy. Acknowledgement letters were sent and timescales were clearly outlined. We saw that action taken in response was responsive and clearly recorded.

The service had an end of life policy in place and had given consideration as to how to support those at the end of their lives. The staff training matrix showed that end of life training had been delivered to some staff in October 2017 and January 2018 and was in the process of being rolled out further. Each care file considered whether someone had a funeral plan in place and recorded the person's wishes in respect of this.

Good

Is the service well-led?

Our findings

The majority of people spoke positively about the care they received and the organisation of the service. Whilst we received some individual reports of poor communication from the office based staff, the majority of people felt that communication and management of the service was good. People told us, "I can't think of anything that could be improved, it's all good, they look after us", "Very well organised, it's very good, I would be happy to spend the rest of my days here" and "Yes, well managed, I would recommend."

People's relatives told us, "Yes, it is well managed, everything runs smoothly we have a good relationship" "Yes, [it's well-led] they try to keep me informed" and "They work really hard, [relative] is doing remarkably well. "

There was a registered manager in post. They had registered with the commission in December 2017. The previous registered manager remained at the service and was the nominated individual for the organisation.

Staff told us the registered manager was a visible and active presence within the service and was supportive. Staff told us; "They're always there at the end of the phone" and "They're the first one here in the morning and last one to leave at night and involved in everything". Staff also spoke positively about the organisation of the service. Comments included; "We're a good team, there's constant training, updates and memos are circulated and there's good communication" and "The service has come on leaps and bounds, staff retention is better, everything's better."

We spoke at length with the registered manager and registered provider who were open and transparent during our inspection regarding some of the issues the organisation had experienced in the last 18 months as they established themselves as a new provider in the area. They described some of the challenges they had encountered through the transfer of undertakings process which involved the acquisition of staff from a number of different providers. The registered provider told us this resulted in a period of increased staff turnover as some staff they inherited were unable to adjust to the culture of the organisation and work to the high standards expected. We saw that these issues had largely been resolved through ongoing recruitment of staff. The registered provider told us they had changed their recruitment process to become more values based to recruit staff whose values aligned with those of the organisation. Staff we spoke with were able to explain the culture and vision of the service, primarily the focus on person centred care, and how they delivered this in practice.

Staff were supported to progress and develop within the organisation through on-going training and progression development programmes. Staff told us that that they felt valued within the organisation and their contribution was recognised through the internal staff recognition schemes such as the 'wow' awards and also through reward vouchers at Christmas. They told us this contributed to them feeling appreciated. The registered provider showed us evidence of their nomination for Skills for Care 'Small Employer of the Year' awards, an achievement they were particularly proud of.

A range of quality assurance systems were in place to ensure that care being delivered was safe, effective and compassionate. These included monthly audits and team leader checks on each supported living property on areas such as medication, care plans and the general wellbeing of people with a focus on whether people's social, emotional and environmental needs were met. These checks were based around the key lines of enquiries that we inspect. On call spot checks had been developed as a means of monitoring staff practice at the service. We reviewed the spot check records completed since November 2017 and saw that senior staff completed ad hoc visits to observe staff interaction, atmosphere and the well-being of people using the service when receiving support.

We saw that members of the senior management also completed monthly visits to the supported living properties on a rotating basis. These visits assessed the property, atmosphere and staff interaction with those living in the home. We also saw that regular health inspection checks were completed on the safety of the premises and people were supported to raise concerns about the property and staff reported repairs on the tenant's behalf. These audits showed evidence of regular monitoring of the quality of care and support being provided.

Performance and board information reports were compiled by the quality and performance manager for the service which analysed areas such as complaints, safeguarding's, staff turnover and accident and incidents. The findings identified an increase in safeguarding incidents at the location and had summarised the reasons why this was the case. The registered provider considered any trends in respect of these areas at their board meetings.

The registered provider had procedures in place to reflect on their service delivery and what they could do better. We reviewed the registered provider's self-assessment completed in July 2017 and saw that they had identified a need for better recording. In response, the service acquired a new electronic database system called 'Iplanit' to improve the accuracy of record keeping. During our inspection, a senior officer showed us how this proposed new system would operate and we saw this was user friendly and effectively designed to meet the individual needs of people receiving care. Features of the new system included the ability for people to devise their own care plan in audio or pictorial format. People's relatives could also access the system as a means of monitoring their loved one's care. At the time of our inspection, the system was not yet embedded and information had just begun to be transferred to the system on a phased basis. We were therefore unable to measure any improvements to the service but the registered manager agreed to keep us updated with their progress.

The registered manager maintained a focus on improvement and outcomes for people receiving care. We reviewed a number of 'case studies' that had been compiled to measure outcomes for individual people. For example, staff recognised that one person who lived in their own independent accommodation was not achieving their full potential due to the inappropriate environment in which they lived. Staff supported this person to move accommodation through liaison with the local housing provider. The case study showed marked changes in the person's well-being and demeanour since moving to their new property including less isolation, an observation echoed by the person's family.

Opportunities were provided for people and their relatives to comment on their experiences and the quality of service provided and people told us they were consulted regularly. Tenant meetings were held in individual properties every 3 months. People were informed about any updates, service news and topics such as household chores, staffing and activities were discussed. The service had recently held their first service user advisory forum meeting in January 2018. Additionally, tenant and family forums were held bi-annually. These forums gave people who used the service and their relatives the opportunity to discuss any changes to the service, the care and support they received and contribute to any future developments. We

reviewed the minutes from the last tenant and family forum meeting held in September 2017 and saw that the registered provider kept people informed regarding the outcome of local authority monitoring visits and any changes planned to the service such as the new electronic computer system. Family newsletters and quality assurance surveys were issued to people using the service, family, carers and staff and the results were recorded and analysed.

The registered manager and registered provider told us of their plans for further development of the service. Two such initiatives were family carers advisory groups and the roll out of the 'quality checkers' initiative. The 'quality checkers' initiative gives people who use the service a role in checking the quality of care delivered and an opportunity to contribute to service delivery through their feedback.

Staff meetings were scheduled on a fortnightly basis. We reviewed the minutes of these meetings and saw these covered discussions around training, recording and audits. Staff told us they also felt confident to raise any issues informally. Regular meetings were also held at management and senior management level to discuss any issues or areas for development.

The registered provider had a range of policies and procedures in place for staff to reference in topics such as equality and diversity, human rights, food and nutrition, and active support. Policies and procedures support decisions made by staff because they provide guidance on best practice.

The service worked with wider partners to ensure people received safe, effective and compassionate care. For example, the service signed up to a keep safe initiative in the local community to ensure that people who used the service received advice and support to stay safe in the local community. The service had also signed up to the Driving Up Quality Code as a sign of their commitment to improving standards of care in learning disability services and the Health Charter in Practice, a resource designed to reduce inequalities in healthcare.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding the service.