United Response

United Response - York DCA

Inspection report

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Date of inspection visit:
05 July 2017
07 July 2017
10 July 2017

Date of publication:
25 July 2017

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 carried out on the 5, 7 and 10 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the main office.

York DCA is owned by United Response and provides services to people with a wide range of complex needs in community settings, such as people's own homes and supported living houses. The service provides domiciliary care and support services from the registered office location in the centre of York.

At the time of this inspection, the provider was providing personal care and support for twenty seven people in villages outside the City of York who had a learning disability or autistic spectrum disorder.

The provider is required to have a registered manager in post and on this inspection, there was a registered manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager will be referred to as 'manager' throughout the report.

At the last inspection in May 2016 the provider was rated as required improvement. This was because they were in breach of two Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in Regulation 12 Safe care and treatment and Regulation 17 Good governance.

We asked the provider to submit an action plan regarding the breaches identified and during this inspection the actions were met. No further breaches were identified during this inspection.

Systems and processes were in place that helped keep people safe from harm and abuse. Staff had completed safeguarding training and knew the signs of abuse to look out for and how to raise any concerns.

The provider ensured there were sufficient skilled and qualified staff to meet people's individual needs and preferences. People received their care and support from regular staff that ensured continuity and consistency.

People received their medicines as prescribed and safe systems were in place to manage people's medicines. Staff were trained in medication administration and their competency was checked regularly.

People were supported to pursue a wide and diverse variety of social activities relevant to their needs, wishes, culture and interests. Arrangements were in place for people to maintain links with the local community, friends and family.

The provider had systems and processes to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence.

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

People and relatives were encouraged to be involved in their care planning as much or as little as they wanted or were able to be. People's records of their care were reviewed and included up to date information that reflected their current needs.

Care workers had a good understanding of people's needs and were kind and caring. They understood the importance of respecting people's dignity and upholding their right to privacy.

There was an effective complaints procedure for people to raise their concerns and these were responded to.

There were systems of audit in place to check, monitor and improve the quality of the service. Associated outcomes and actions were recorded with timely outcomes and these were reviewed for their effectiveness.

The provider worked effectively with external agencies and health and social care professionals to provide consistent care.

Everybody spoke positively about the way the service was managed. Staff understood their levels of responsibility and knew when to escalate any concerns. The manager had a clear understanding of their role and responsibilities and requirements in regards to their registration with CQC.

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.

Care workers had received training in safeguarding adults and understood the signs of abuse to look out for and how to report any concerns.

There were sufficient numbers of appropriately trained staff with the required skills and knowledge to support people according to their needs.

Care workers received training and policy and procedures were in place that ensured people received their medicines safely as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills to provide good care to people.

Care workers we spoke with understood the importance of ensuring people consented to the care and support they provided and had an understanding of the Mental Capacity Act 2005.

There were systems in place to support people to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

We observed the service provided person centred care and it was clear the care workers had an understanding of people's needs.

People were treated with dignity and their privacy was respected.

Care workers encouraged and supported people with their independence.

Is the service responsive?

Good

The service was responsive.

Effective systems were in place to respond to any concerns and complaints raised.

Care plans were reviewed as a minimum every six months or more often where people's needs changed.

People's views and opinions were sought in a variety of ways and their ideas and suggestions were responded to.

Is the service well-led?

Good

The service was well led.

Quality assurance systems and audits with associated action plans were used to maintain and drive forward the required improvements in the home.

Everybody spoke highly of the registered manager and the organisation. Staff understood their roles and responsibilities.

The provider sought and acted on the views of care workers and people receiving care and support to improve the service provided.

United Response - York DCA

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 on the 5, 7, and 10 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the main office.

One adult social care inspector undertook the inspection and they were assisted by an expert by experience. The expert by experience had previous knowledge of experiences of people with learning disabilities in a similar setting.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the provider. Notifications are when providers send us information about certain changes, events or incidents that occur.

The provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spent time visiting people in their own home and spoke with four people receiving a service. We interviewed six care workers and we spoke with three service managers and the registered manager. After the second day of the inspection we spoke with four relatives of people receiving a service over the telephone.

We looked at records, which related to people's individual care; this included the care planning documentation for six people and other records associated with running a community care service. We also looked at eight care workers recruitment and training records, records of audits, policies and procedures and records of meetings and other documentation involved in the running of a domiciliary care agency.

Good

Is the service safe?

Our findings

At our previous inspection in May 2016 we found that administration of people's medicines were not maintained or complete and failed to ensure people received their medications consistently as prescribed in a safe way. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan to meet with the breach of this regulation by September 2016 and the actions had been completed.

During this inspection we looked at the provider's management of medicines. Medicines management policies and procedures were in place. Care workers recognised the importance of administering and recording people's medicines. Comments included, "We all have regular training and spot checks are completed to make sure we are doing everything correctly." Training records we looked at confirmed this.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. We looked at Medicine Administration Records (MAR) for six people. We found these were up to date and correctly completed by care workers after people had taken their medicines. Systems were in place to ensure medicines were ordered, stored and administered safely and checks were carried out on a daily basis to ensure the manufacturer's guidance was adhered to.

We looked at the records maintained for people's medicines and saw that the provider completed risk assessments and developed care plans. The records included how people preferred to take their medicine and the support they required. Some people who required medicines to maintain their health and well-being were unable to provide their consent. Documentation and records provided robust guidance and information for care workers to ensure that where people could not agree to their medicines, they received them as prescribed in line with best interest decisions; following the legal guidance under the Mental Capacity Act 2005. During our observations of the administration of medicines, we saw people's preferences for the way they wished to take their medication was respected and implemented. A relative we spoke with told us, "[Name] always receives their medication on time; when they come to stay with us all their tablets are set out in day and time order in dispensing trays, there never seems to be a problem."

The provider completed additional audit checks as a minimum every quarter at each home. These included checks on processes for medicines management and record keeping. This meant systems and processes were in place to ensure people received their medicines safely as prescribed and records were accurately maintained.

Systems and processes were in place to keep people safe from avoidable harm and abuse. One person said, "I feel safe here, I don't have any worries but if I did I would tell this lovely member of staff." The provider had a policy and procedure on safeguarding that along with training ensured care workers understood the types of abuse to look out for and how to escalate their concerns. A care worker told us, "If I observed bad practice, my prime concern would be to maintain the safety of the person, rather than confronting the abuser. Once the person was safe I would follow procedure and escalate the incident for investigation."

The manager showed us how safeguarding concerns were recorded and managed electronically. Where appropriate to do so, these records were escalated to the council for further investigation and submitted as notifications to the Care Quality Commission. The manager said, "We look at all incidents and they are evaluated for any trends by the health and safety manager; where any trends are identified we review practice and include other health professionals to help protect people from further instances."

People were supported to live their lives as they choose to and we saw risk assessments were in place which supported this approach with minimal restrictions in place. Care plans we looked at included comprehensive assessments associated with people's care and support. Where risks had been identified, these were recorded and support plans helped to keep people safe. The risk assessments covered areas of daily life which the person may need support with. For example, personal hygiene, mobility, seizures and behaviours which may challenge the service or place the person and others at risk. These were detailed and provided care workers with guidance in how to mitigate the risks and keep people and themselves safe. We saw the risk assessments were reviewed for their effectiveness and included input and guidance from other health professionals. A care worker said, "There are risk assessments for almost every situation and we review these every six months or sooner if necessary."

Other checks were completed at people's properties and the provider had contingency plans in place to keep people safe in the event of an emergency situation for example a natural disaster. This included fire, flood, illness and other events that could affect the service. Care plans included 'Missing people' information. This had been discussed and agreed with the police to ensure a person could be identified in the event they went missing. We saw information included a photograph, a brief overview about the person and detailed any medication the person may have been taking.

We looked at staff rotas which confirmed there were sufficient care workers on duty at the time of our inspection. People and care workers told us there were enough care workers available to meet people's needs and they did not have any concerns about staffing levels. Observations during our inspection supported this. In all three homes that we visited care workers told us any staff absences were covered internally. A service manager told us, "United Response is our first port of call should we have staff absence; we have a 'relief pod' made up of accredited care workers who are well known to most people and other care workers." This helped to ensure people received a consistent service. A relative we spoke with said there was always plenty of care workers whenever they visited. They said, "Care workers are always on hand if me or [name] need them and they are well organised." One person confirmed, "Yes, there is always regular care workers on duty here."

Recruitment was managed safely. We looked at the recruitment checks in place and saw that the dates were recorded for when references and Disclosure and Barring Services (DBS) checks had been received. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. It was clear that these checks had been undertaken and that the provider had received this information prior to the new employees starting work with people.

Good

Is the service effective?

Our findings

At our previous inspection in May 2016 we found accurate and complete records were not maintained to ensure care workers had sufficient information to act in people's best interest and provide care and support using the least restrictive option. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan to meet with the breach of this regulation by September 2016 and the actions had been completed.

During this inspection we checked and found the service was working within the principles of the Mental Capacity Act 2005 (MCA). 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. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) and in where care is provided in people's own homes this is authorised by the court of protection.

We saw people were asked for their consent before any care interventions took place. People were given time to consider options and care workers understood the individual ways in which people indicated their consent. This included non-verbal communication. People's ability to provide consent was assessed and recorded in their care plan.

Decision making profiles were in place to ensure people received information in a way they could understand and to promote their choices. Profiles were in place and included food choices, medicines, daily activities, personal care, what to wear, holidays and expenditure for large items. Where people had been assessed as lacking capacity and had restrictions in place, the provider had completed applications to the council. The council are responsible for further assessment regarding people's mental capacity. Where these are approved, they will submit applications to the court of protection to legally deprive people of their liberty. The manager was awaiting the outcome of these applications.

Best interest decisions to provide people who were assessed as not having full capacity with care and support, were recorded and these documented who had been involved, the reason for the decisions and the outcome. The meetings were attended by a range of healthcare professionals and other relevant people who had an interest in the person's care and welfare. Care and support provided as a result of best interest decisions was reviewed for effectiveness and further meetings were held where changes were required. This meant people received care and support that was agreed as being in their best interest and the least restrictive option.

Throughout the inspection we saw care workers gaining people's consent before care and support was provided. Care workers we spoke with were able to give us an overview of the MCA and how they assisted and encouraged people to make choices and decisions. One care worker said, "It's about knowing people, always assuming they have capacity to make their own decisions and encouraging them to be as independent as possible."

It was clear from our observations with people and from talking with care workers that they were skilled in their role and understood people's needs. A care worker told us, "There is a lot of training that we complete routinely and training for anything else we need to know to support people."

Care workers told us and we saw from their records they completed an induction and a period of shadowing existing care workers before they commenced independent duties with people. Training records confirmed care workers had received generic training on topics that included fire safety, health and safety awareness, moving and handling, medication, basic food hygiene, equality and diversity, safeguarding, dementia, challenging behaviour and the MCA. Where a person required specific areas of individual support, for example with epilepsy and autism; care workers had received training in epilepsy awareness and administration of prescribed Buccal Midazolam. Buccal Midazolam is a specific medicine prescribed by a medical practitioner or nurse prescriber for the control of prolonged or continuous seizures which can be a lifesaving procedure.

Care workers received annual observations that ensured they were competent in their role and these identified any areas where they could improve their practice. Care workers received regular supervision and an annual appraisal. This ensured they were supported in their role and had the appropriate skills and knowledge to provide people with safe care and support.

We saw people's care plans contained information about their medical needs and how care workers were to support them to maintain a healthy lifestyle. Previous and current health issues were documented in people's care plans and healthcare professional were contacted when support was needed. Examples included epilepsy nurses and dieticians. People were supported to access their GP when required and regular reviews were undertaken to ensure their health and wellbeing was maintained.

People's dietary intake was closely monitored by care workers and healthy eating was promoted. Records confirmed that healthcare professionals were involved with people's dietary needs and visits were made when required. One person told us they had just returned from seeing their podiatrist. They were able to name their GP, dentist and optician. A care worker told us, "Most people attend community based health professionals, although one dentist visited the home to see a person as this was the least stressful option for them."

The provider had a variety of measures to ensure people could be communicated with. Care plans included detailed information for care workers to follow to communicate with individuals depending on their ability and preferences. A care worker said, "Everybody has a way to communicate, some just tell us or others might use body language or blink their eyes. For other people that are non-verbal we use Makaton and signing." Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

Good

Is the service caring?

Our findings

Everyone we spoke with told us how caring and compassionate care workers were, both with people and to each other. Experienced care workers ensured that new care workers and people were matched. We were told that people were regularly asked if they were happy with their care worker and if they were not arrangements were made to ensure people received care from the most appropriate person to meet their need. Our discussions and observations confirmed this. One person told us, "Everyone asks me if I am happy here all the time, this lady [care worker] here is lovely." A care worker said, "We are a great team throughout with one main goal; to provide the best care and support for people." A relative we spoke with confirmed, "I am very happy with the care [name] receives; they are very safe."

We saw people who used the service and care workers had good, respectful relationships. Care workers were aware of people's needs and the support required leading a fulfilling life. There was lots of laughter and good humour around people's homes and it was clear people enjoyed the care worker and each other's company. People were seen to approach care workers with confidence; they indicated when they wanted their company, for example when one person who used the service heard the voice of a care worker they liked coming into the service they greeted them excitedly and the care worker responded to them in a kind and friendly way, asking them how they were. We observed care workers engage people constantly in conversations using their preferred method of communication.

Care workers routinely promoted people's independence. Daily tasks were shared between people and their care workers. For example, we saw a care worker putting out one person's washing and the person helped by passing clothes and pegs. Another person took great delight in putting the finishing touches to a communal meal that had been prepared. A relative told us, "[Name] has freedom of choice, it is naturally encouraged; I wouldn't be very happy if it wasn't."

Care workers understood how to maintain people's confidentiality. They said, "We hear everything but we don't discuss things that people have told us; it's private" and "It's a need to know basis; we don't say or tell anybody anything we hear unless it is relevant to the person's safety or wellbeing."

We observed care workers knocking on doors and asking if it was alright for them to come in before entering people's private rooms and occupied toilets. A care worker described how they would uphold someone's dignity. They said "I always treat people how I would wish to be treated; it is common sense really, for example, keeping them covered up as much as possible during personal care and giving them their own time as long as they are safe."

Relatives told us they were kept informed about people's lives. One said, "They [care workers] update me if they have any concerns and when [name] has done something worth celebrating." Relatives told us they were invited to attend reviews of people's care. A care worker said, "It's important for people that we communicate on their behalf with their families, if that's what they want. We use a variety of methods to keep relatives informed; we use telephone, email and electronic application. The level of contact is decided by people and agreed with their relatives."

Where people did not have close family to support them the manger told us they had the option to use an advocacy service. An advocate's role includes making sure correct procedures are followed and making sure the person's voice is heard.

People had been consulted on their wishes and preferences for end of life care and support. Where they had agreed, this information was available and recorded in their care plans.

Good

Is the service responsive?

Our findings

People received personalised care and support. Everyone knew what needed to be done and care workers were proactive in supporting people to meet their needs.

Everybody who received care and support had a care plan in place and we saw these were reviewed as a minimum every six months or sooner where people's needs had changed. For example, we saw reviews were completed after a period in hospital, when a GP had changed a person's medicines or when repeated incidents had been evaluated and as a result, risk assessments had been updated. This meant records provided those individuals involved with the person's care and support with up to date information and guidance that was reflective of the current needs. A care worker said, "Care plans contain inclusive information about a person, the information is up to date and we can refer to them for every aspect of a person's daily routine."

We saw from care plans that where ever possible people were involved in discussions regarding their care. One care plan recorded an annual review that had been completed with involvement from the person, their key worker, family members and a reviewing officer from the Council. The service manager told us, "We always try and involve people but it can be difficult at times. We try different approaches to engage people because after all it is about and for them. For example [name] likes chocolate so we made a cake and had chocolate as the theme around the review; the person engaged and we managed to get their input and agreement to some areas of their care plan."

Care plans contained a spider web pictorial that showed the individuals who were closest to the person with their names at the centre of the web and others involved in their care documented away from the centre. This was reviewed as people's needs changed and helped to ensure that the care delivered was responsive to the person's changing needs.

Care plans contained information that was written from the person's point of view and people's personal daily preferences were recorded. A one page profile included a photograph of the person, what people admired about them, what was important to them and included information to guide care workers on how to support them. Other information recorded what the person liked or disliked about daily life. This recorded a person's preferences, wishes and useful information that helped them to receive personalised care and support.

We saw records included details of people's choice of food and whether they liked to have a lie in bed in the morning and how they liked to spend their day. Information about individuals involved in people's lives was recorded and relatives confirmed they were able to visit people and take them out without any restrictions.

During our inspection we observed people led active lives. One person showed us their room that they had personalised with pictures, models and a shelf full of electronic games. The person was interested in sport and trains and this was actively supported. They showed us their bus pass and a care worker discussed how they accompanied the person to the train station and on other days out to keep them safe. We observed as

the care worker stood back whilst the person prepared their own packed lunch; a few suggestions from the care worker were sufficient for the person to collect their favourite sandwich filler, butter their bread, find a pack up box, make a drink and pack their bag. The care worker told us, "[Name] is very capable and only needs a bit of guidance from time to time but if were not careful, they would let us do everything for them."

People received support and were encouraged to participate in activities of their choosing. Care plans included detailed information about the activities and interests that people liked and disliked. People had been consulted on their preferences, how they wanted to be supported and the amount of and type of support was recorded in their care plans. Information was outcome focused and recorded when people had completed activities and tasks and celebrated successes.

Other activities that we saw people had participated in included support with going to church, day clubs and going on holiday. When we asked if there was enough time for care workers to support people as they have chosen to be supported a care worker confirmed, "As well as designated activity days, people have weekly one to one days with their support worker who will spend the day supporting the person to follow their chosen activity. It may be grocery or clothes shopping, swimming, a day trip; whatever they choose to do." We observed one person researching a favourite famous person. The care worker helped them to use their laptop and reference books, going through photographs, and reading text out loud. Discussion with the person ensued about the kind of life the famous person would have lived. It was clear this was a subject of interest for the person who was deeply engaged and we noted a picture of the individual on their laptop screen.

We saw people had a health passport in their files for use should they need to transition between services. This documented any medication, health concerns and other personal information and was in an agreed NHS format. This meant people were supported and had their needs recognised should they have to transfer or move to services, more appropriate for their needs and helped to ensure they continued to receive consistent coordinated care.

People were encouraged to provide feedback, share their experiences or raise any concerns. We saw people were asked about their care and support and any concerns were recorded at reviews. We saw minutes from tenants meetings where people put together an agenda, discussed a range of issues and celebrated achievements.

Care plans included information and guidance on how to raise complaints. A service manager said, "The guidance is available for information only; we work with people daily to ensure they are happy with the care and support they receive." They told us most concerns were dealt with as they happened on a daily basis and that they would support people through the complaints process where that was required.

Care workers told us how they recognised when people were not happy. One care worker said, "I have worked with [name] for a very long time, I know when something is wrong by their body language and mood." Another care worker said, "People know how to complain, they soon let you know if they are not happy, we haven't had any formal complaints as people generally seem to be very happy; if we do, we would follow the policy and procedure and they will be investigated and responded to."

The manager told us, "All complaints are investigated and responded to, with any actions or recommendations documented and implemented." They showed us a complaints log. The last complaint was in October 2016. We saw information included the nature of the complaint, an investigation, outcome and dates when it was resolved. The manager said, "The process has higher level management oversight to ensure the process is robust and fair." This meant systems and processes were in place to ensure people

were supported to raise concerns and complaints and ensured they were responded to.

Good

Is the service well-led?

Our findings

At our previous inspection in May 2016 we found that accurate and complete records were not maintained to ensure care workers had sufficient information to act in people's best interest. Standards of record keeping were observed to be inconsistent across the homes we visited. We saw evidence that medicine records, care plans and risk assessments were not always accurate or up to date and quality assurance checks including audits had failed to identify and address the breaches we found. This meant that care workers did not have access to up to date and complete records in respect of each person using the service, which potentially put people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan to meet with the breach of this regulation by September 2016 and the actions had been completed.

During this inspection we found the provider had implemented improvements in the way they maintained and improved the quality of record keeping and the associated services. The manager showed us a quarterly audit completed at each home where people received a service. The audit was completed by a manager without direct operational responsibility for the service being checked. Oversight and further evaluation of the outcome of the audits was completed by an area manager and reviewed by the quality management co-ordinator.

Areas that were checked included, financial checks, completion of supervisions with care workers, health and safety checks that included recording and monitoring of medicines management, a checklist for people's records, reviews of support plans and risk assessments, care worker observations, the environment and other areas previously identified for improvement. The audits included comments that recognise any good work in evidence that could then be implemented as best practice at other people's homes. The manger told us, "The audits are good and we have seen improvement as a result of their implementation; for example, the numbers of medication errors have reduced significantly."

We saw care records were reviewed at least every six months. Records were organised and available for us to inspect. We found consistent processes had been implemented throughout the homes we visited. A care worker said, "We can go into any home and we know where the information we need will be and can quickly update our knowledge and then get on with supporting people, it is so much better than it used to be." This meant that care workers had access to consistent, up to date and complete records in respect of each person using the service.

The manager understood their responsibility to ensure the CQC was informed of events that happened at the service which affected the people who received a service.

The manger was supported by a team of higher level management and service managers who had responsibility for care workers in people's own homes. Everybody we spoke with told us they found the manager open, honest and approachable. Feedback included, "[Manager] is approachable and supportive," and "They [manager] are fairly new in post but they are more than capable." A relative told us, "The service is very well led. We know the senior support workers very well and they are always on the ball; the manager is

marvellous." We found that management was clearly involved with every aspect of the service.

Care workers told us they enjoyed working for the service and were happy with the support they received. They told us, "We are very well supported with good training", "We are listened to and we have good rotas which mean we can have two full days off each week" and "Senior staff always support us with whatever we need."

Care workers told us how staff meetings kept them informed about any changes and provided them with an opportunity to discuss people's individual needs. This included what was working for people, what required improvement and any areas of concern they had. A care worker confirmed "We have regular staff meetings; we discuss all sorts of issues, about new events that are taking place and what is working or is not working." We looked at minutes from staff meetings. We saw previous meeting actions were discussed and outcomes reviewed. Items that worked or did not work for people for example, a day trip for one person was a success but sleeping was a problem. We saw the successes were celebrated and actions were discussed and implemented where things did not work. In this example the action was to provide the person with further stimulation and activities during the day. Other agenda items were discussed including, staffing, gardening and record keeping.

The provider sent out short questionnaires to people receiving a service to gauge their feedback on care workers who worked to support them. The questionnaire was in an accessible format with pictures, text and symbols that people could select to answer the questions. We saw this was used as part of supervisions to improve practice and recognise positive contributions.

People who received a service were supported to be part of the community. Where they were able to, people were encouraged and supported with opportunities to work. The provider had a service in place called, 'The Boot Shop'. The Boot Shop provided adults with learning disabilities, the opportunity to take up a range of employment opportunities. We saw that people helped with administration duties in the main office and were encouraged to take up paid and voluntary employment in the community.

Accident and incident records were maintained and demonstrated immediate appropriate actions were taken following these. The manager confirmed how all accident, incident and safeguarding reports were sent to the senior management team including the health and safety manager, for analysis and review in order to identify any emerging patterns and outcomes to inform learning at both service and organisational level.

The provider promoted the visions and values of the service. We saw literature that included a poster entitled 'What we do and what we do not do'. For example one item read, 'We don't do things for you; we do things with you.' A statement of purpose was made available and included information on the service, contacts and accessibility. This had been updated in July to include details of the new manager.

The manager told us how they attended meetings on a regular basis with other service managers. They told us this helped to maintain and develop their practice to ensure the service upheld the visions and values of good care and support for people.