United Response

United Response - Central Lancashire Supported Living

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection visit took place on 21, 22 and 23 November 2017 and was announced. We last inspected United Response - Central Lancashire Supported Living on 16 & 17June 2016. At that inspection, we found that people's safety was being compromised in a number of areas. This included how people's medicines were managed, managing risk to receiving care, a lack of person centred care and safe care and treatment. There was also a failure to provide good governance. These were breaches of Regulation 12 and Regulation 13 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent us an action plan, which set out what action they intended to take to improve the service.

During this inspection we reviewed actions the provider told us they had taken since our last inspection to gain compliance against the breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified. We saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service. We found improvements had been made in order to meet the regulations in relation to medicines management and risk management. However; we found on going shortfalls in relation to governance and the oversight provided on staff.

United Response-Central Lancashire Supported Living is registered to provide personal care and support for people living with mental health needs and/or living with a learning disability or autistic spectrum disorder. This service provides care and support to people living in 19 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of the visit there were 42 people who used the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. The values aim to ensure people with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the time of our inspection there was no registered manager in post. There was an area manager who was overseeing the running of the service and an interim manager who was in the process of completing an application to become the registered manager. 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 provider had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. Before the inspection we had received allegations of abuse. We informed the local safeguarding authority. They were undertaking safeguarding enquiries at the time of our inspection.

People and their relatives confirmed people were encouraged and supported to maintain and increase their independence. Some people who used the service had limited ability to provide us with feedback on the service due to their needs. We observed their interactions with care staff. Feedback from relatives about care staff was positive.

Recruitment checks were carried out to ensure suitable people were employed to work at the service.

During the inspection we noted there were adequate numbers of staff to meet people's needs. Staff had received induction, supervision and training. 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 at the service supported this practice.

Risk assessments had been developed to minimise the potential risk of harm to people who used the service. These had been kept under review and were relevant to the care and support people required.

Care plans were in place detailing how people wished to be supported. People who received support, or where appropriate their relatives, were involved in decisions and consented to their care. People's independence and choice was promoted.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required. We noted improvements in medicines management practices.

People's care needs were discussed with care commissioners before they started using the service to ensure the service was able to meet their assessed needs. Care plans showed how people and their relatives were involved in discussion around their care. People were encouraged to share their opinions on the quality of care and service being provided. People's nutritional needs were met. Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed.

There was a variety of meaningful activities to keep people occupied and to promote social inclusion. People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

There was a policy to support people at the end of their life to have a comfortable, dignified and pain-free death.

We received positive feedback from staff regarding the management and culture in the service. The manager understood their responsibilities, and was supported by the provider and other managers to deliver what was required. However, we found that there had been a lack of consistent oversight on staff following the departure of the registered manager. The area manager and the interim manager had identified the shortfalls and had started to rectify them. We have made a recommendation about management seeking training on governance.

There were a variety of methods used to assess and monitor the quality of service provided to people. These included regular internal audits of the service, surveys and staff and relatives meetings to seek the views of people about the quality of care being provided.

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 told us they felt safe. Feedback was positive.

Risks to the health, safety and well-being of people who used the service were assessed and plans to minimise the risk had been put in place.

The use of physical restraint had been considered as the last resort and used proportionate to the risks posed.

People's medicines had been safely managed. Staff had been trained and competence tested for safe administration of medicines.

Staff had been safely recruited and disciplinary measures were in place.

Is the service effective?

Good

The service was effective.

The rights of people who did not have capacity to consent to their care were protected in line with the MCA principles. Improvements were required in relation to MCA training and record keeping.

Staff had received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

People were adequately supported with their nutritional needs and record keeping had improved.

People's health needs were met and specialist professionals were involved appropriately.

Is the service caring?

Good

The service was caring.

Relatives spoke highly of care staff and felt their family members were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of the people they supported. The service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible.

Is the service responsive?

Good

The service was responsive.

People had well written plans of care which included essential details about their needs and outcomes they wanted to achieve. Records were comprehensive and detailed.

The service had a strong emphasis on community involvement and keeping people active and engaged to reduce social isolation.

There was a person centred approach to care planning and care was reviewed regularly with people and their relatives involved.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their family member's care and treatment.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in post. People gave positive feedback about the area manager and the provider.

Improvements were required to the oversight provided on staff across the service. There had been lack of oversight due to the lack of a registered manager. A new manager had been identified.

Feedback from staff regarding management and the culture of the service was positive.

People and their relatives had been consulted about the care provided.

Policies for assessing and monitoring the quality of the service

were in place and visions and values were shared with people and their relatives.

United Response - Central Lancashire Supported Living

Detailed findings

Background to this inspection

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

This inspection site visit took place on 21, 22 and 23 November 2017 and was announced.

We gave the service 24 hours' notice of the inspection visit because it is a domiciliary care service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of three adult social care inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The experts undertook telephone interviews with people and their relatives on 22 and 23 November 2017.

Before our inspection visit we reviewed the information we held on United Response - Central Lancashire Supported Living. We gained feedback from health and social care professionals who visited the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts, information from whistle blowers and statutory notifications sent to us by the registered provider about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us.

Prior to the inspection we had received allegations of abuse against two care staff. We passed the concerns to the local safeguarding authority and the provider started their own investigations in line with their own safeguarding policy. We also explored how safeguarding concerns were managed in the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We visited seven properties with people's permission to observe how people were supported in their own homes. We were unable to speak to some people due to their communications needs. We observed their interactions with staff. We met nine people and seven care staff and one relative. In addition we emailed all staff who worked at the service. We spoke with the area manager, two service managers including the interim manager.

We looked at care records of nine people who used the service, five staff recruitment records, staff training records and records relating to the management of the service. We also contacted the safeguarding department at the local authority, the local mental health trust and Healthwatch.

Good

Is the service safe?

Our findings

At our last comprehensive inspection of United Response-Central Lancashire Supported Living in June 2016, we found there was a failure to ensure that people's medicines were managed safely, and a failure to provide safe care and treatment. There was also a lack of robust risk monitoring and management. These were multiple breaches of Regulation 12 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we reviewed the actions that the provider told us they had taken to gain compliance against the breaches in regulations identified at the previous inspection in June 2016. We saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service. We found improvements had been made in order to meet the regulations in relation to medicines management, and risk management and the provider was compliant in these areas.

We reviewed how the service protected people from abuse, neglect and discrimination. People we spoke with and their relatives told us they felt safe using the service because they trusted the staff that supported them. Comments from individuals who used the service included, "I know I am safe, I know who I can talk to if I am worried, and staff help me work things through." "Yes, I feel safe(Names of staff) do really well with me." And "Yes, they are friendly, very friendly."

One relative we spoke with told us their family members were kept safe by the service. Comments included, "I definitely think [my relative] is safe here. He has a set of staff that know him very well. They are well trained." The staff do a marvellous job and it is always very clean and hygienic when I call." One member of staff told us; "To help people stay safe, we keep an eye on them. We've had training on challenging behaviour, health and safety."

A social worker told us, "I have met the managers and made recommendations on keeping people safe and staff have followed these. Staff seemed attentive and caring."

Before this inspection we received allegations of abuse. We also received concerns from a whistle-blower regarding the quality of care provided in one of the properties where one person lived. We reported both concerns to the local safeguarding team. The service took action in line with their own safeguarding and disciplinary policies to investigate the concerns and take appropriate action. The concerns were still under consideration by the local safeguarding team at the time of our inspection.

Staff had received safeguarding training at the beginning of their employment and undertook refresher training. We found safeguarding procedures took into consideration the wishes and feelings of people and their relatives. Staff we spoke with knew how to report safeguarding concerns and were confident their concerns would be taken seriously.

Before the inspection we had received a number of notifications on incidents including altercations between people who used the service. We reviewed the records relating to these concerns and action taken

with the provider. We found appropriate action had been taken.

Risks to people were assessed and their safety was monitored and managed so they were supported to stay safe and their freedom was respected. The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. We found examples of positive risk taking approaches. Staff we spoke with demonstrated a positive risk taking approach which was underpinned by a desire to ensure people's freedom was not limited due to risks around them. One staff member told us; "I am most proud of how we as a team have supported people with very complex needs to fulfil lifetime challenges and special experiences, including holidays with support staff and outdoor activities such and getting out and about in the community regularly."

We also found staff had completed separate assessments which identified any specific needs or risks. They had then developed positive behaviour support plans. These support plans were well detailed and comprehensive. They contained guidance on how people would present in different situations and proactive strategies that staff could use to prevent certain the situations from escalating. There were plans of action on how to support people which were further supported by a series of risk assessments.

There were policies and procedures to protect people from the risk of financial abuse and to protect their money. However, we noted further improvements were required to reduce the risks of thefts and to support people so that they manage their finances safely. The area manager assured us that financial practices were reviewed following an incident and have continued to be improved. This should ensure that people's finance would be protected.

There were noted improvements to medicines management. The records we checked and conversations with staff demonstrated that the provider had systems for ensuring the proper and safe use of medicines. Staff designated to administer medicines had completed a safe handling of medicines course and undertook competency tests to ensure they were competent at this task. Staff had access to a set of policies and procedures which were readily available for reference. In addition people were supported to manage their own medicines independently. Staff had assessed that they were safe to do so.

We noted the medicines administration records for medicines were well presented and organised. Medicines audits (checks) were in place and we saw daily and monthly checks carried out by the service managers, senior staff and management. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to receive their medicines safely. Where errors have been found, staff had been provided with support, such as further training in medicines management before they would be allowed to administer medicines unsupervised.

We found there were suitable arrangements for the management of creams such as topical creams and temperatures were monitored in rooms where medicines were stored. This ensured that the integrity of the medicines were not compromised.

We looked at how the service made sure that there were sufficient numbers of suitable staff to support people to stay safe and meet their needs. We looked at the staff rotas for the service and the provider had planned the staffing requirements for each property ahead. Comments from staff we spoke with indicated that there were sufficient numbers of staff to ensure people's needs were safely met. Comments included; "Our staffing levels are getting better, things have improved." Another staff member said, "There definitely is enough staff unless someone is sick, that can't be avoided." And, "We can have agency staff if we are really struggling." This would ensure that people's needs would be met in a safe and timely manner.

Evidence we saw showed that there was a system to allow the organisation and staff to learn and make improvements when things went wrong. For example, there were de-briefing meetings after any physical intervention and where errors such as medicines errors had occurred. Staff had received supervision and discussed ways to improve their practices. The management team also met monthly to discuss any issues arising, areas of improvement and best practice.

We looked at the records of five staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the service. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the service.

There were policies in the service to protect people from risks of infection. Staff had received induction on infection control and prevention. Staff who supported people with food preparation had received food and hygiene training. This would help to ensure people would be protected from risks of infections.

Good

Is the service effective?

Our findings

Relatives of people who were supported by United Response-Central Lancashire Supported Living told us they felt the staff were appropriately trained. In addition they had the necessary skills and abilities to meet their needs. Comments from people included; "Staff ask what I like, and listen to me. I choose my own food.", "I like being asked what I think", "Yes" I can choose my own food, carers take me shopping for food, and they help him choose healthy food." And; "Staff really do have skills above and beyond the call of duty."

Staff feedback about training was positive. They told us they received training regularly and can ask for additional training if they required it.

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 Mental Capacity Act (MCA). The procedures for this in supported living and are called the Court of Protection authorisations. The nominated individual informed us that they had routinely notified the local authorities if they felt the care they provided resulted in restrictions on people's freedoms. None of the requests had been authorised due to backlogs at the local authority. The manager was regularly checking progress of the other applications.

People and their relatives informed us that staff sought consent and considered people's mental capacity while providing care support. Care files demonstrated staff had ensured that people or relevant relatives and professionals who acted on their behalf, were involved in and agreed to the care delivered.

We found mental capacity assessments had been completed for when people were required to make significant decisions about their care. Best interest decisions had been completed where people lacked mental capacity. Consent records had been completed. There was an up to date policy in relation to seeking consent and mental capacity. Staff we spoke to were knowledgeable and showed an awareness of MCA principles. They also informed us that there were on-going discussions within team meetings and supervision around mental capacity principles.

We looked at how the provider ensured that people's needs and choices were assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. Records we reviewed showed that people's physical, mental health and social needs were holistically assessed, and their care, treatment and support delivered in line with legislation, standards and evidence-based guidance. For example staff had been trained in positive behaviour support which recognised how people can communicate through their behaviour and how staff should respond. Behaviour was seen as a form of communication which staff needed to understand.

We reviewed the training records for the whole service and found staff had received regular training. They had also been provided with supervision, however this was not always consistent throughout the staff team. Induction was offered to all staff before they commenced their role. This included spending time shadowing experienced staff. Following their induction staff completed training that was specific to the needs of people

they supported. For example staff had received; training in areas such as autism, managing and supporting people who display behaviours that challenge and positive behaviour support. In addition staff were required to complete refresher courses online using e-learning. In majority of the cases staff had completed their e-learning when it was due.

We saw evidence of staff following best practice to support people. For example staff explored different way of facilitating communication with people who had limited verbal communication skills. They were utilising the sign language, Makaton and pictures to assist people to communicate their needs and choices. Makaton uses signs and symbols to help individuals who cannot communicate efficiently by speaking.

We found the service provided care and treatment to people who could display behaviours that can challenge others. Records we saw and conversations with staff and relatives demonstrated that there were instances where it had been deemed necessary for staff to use physical restraint and medicines to calm individuals where their behaviour had posed a risk to themselves, others and/or property. There were policies and guidance to ensure that where this was necessary, it was used in a safe, proportionate, and monitored way as part of a wider person-centred support plan. Staff had received training in the safe use of physical restraint. Staff had been instructed to use restraint as the last resort. They were guided to use other strategies to de-escalate the situation before restraining a person.

Staff had received training in positive behaviour support care planning, to support the needs of people whose behaviours might challenge others. Positive behaviour approaches are specialist approaches, such as applied behavioural analysis and positive behaviour support, which are intended to enhance the quality of life and opportunities by establishing consistent supported approaches that supports the individual and reduces the potential for challenging behaviour. All people had positive behaviour support plans that provided staff with guidance on supporting people effectively.

Care files were clear in their guidance to support the staff to meet the individual nutritional needs of people. Staff had clearly identified people who required support with their nutritional needs. Files had evidence that a nutritional risk assessment had been completed that identified what support people required. Where specialist nutritional support had been identified for example; where there was a risk of choking, care plans and risk assessments had been developed. These were thorough and contained detailed guidance to support staff in providing safe care whilst minimising any risks. Staff had started their training in nutritional support and were due to complete this.

Staff had ensured that people's individual needs were met by the adaptation, design and decoration of their properties. People's environments were appropriately adapted to safely meet people's needs. For example access to the properties and to bathing facilities in some properties had been adapted to ensure people had easy access. Properties were decorated with people's own pictures and personal items. In one property the bathroom required attention. We pointed this to the manager and they took immediate action to inform the landlord. We found the service had utilised technology such as broadband and modern communication methods to enhance the delivery of care.

We looked at how people were supported to live healthier lives, have access to healthcare services and receive on going healthcare support. The service had links with other healthcare professionals, which was recorded in people's intervention and treatment plans. People had health care action plans and received regular health checks where required. For example people living with conditions such as diabetes.

There was also clear evidence of the service seeking advice and support from other agencies and we saw that guidance from healthcare professionals had been incorporated in people's care plans. For example, we

saw that one person had complex needs. There was detailed analysis of their needs and the required interventions which included learning disabilities nurses, psychologist and GPs. There was guidance and contact details for specialist professionals to ensure people received seamless care. This demonstrated that staff within and across the organisation worked together to deliver effective care, support and treatment.

Good

Is the service caring?

Our findings

We received positive comments about the care staff and the service delivered to people. Comments from people included, "Best place I've ever lived at, staff are great," "Staff are very nice." And "I'm happy with care and carers they are nice and kind to me." "They make me laugh; they are funny and friendly all the time." Comments from relatives included "The staff do treat [my relative] with kindness and compassion, definitely." and "I have confidence in the staff they try their best."

Our observations and our conversations with people showed that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. For example we saw a staff member directing a person away from harm by talking to them gently and asking them to follow them. We also noted people being sensitively supported to ensure they maintained their dignity. Staff spoken with and the service managers had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "With working so closely with people and for so many hours a week, you get to really know the person. We are a caring staff team and want the best for the people in our care" and "I like my job and I enjoy supporting people."

We considered how people's dignity was maintained and promoted. We noted people's daily records and care plans had been written in a way that took consideration of their choices and preferences. People had been asked about their likes and dislikes and this had been included in their daily support. Staff we spoke with talked about people in a respectful, confidential and friendly way. Guidance had also been provided on how to approach people and what to say when they appeared distressed.

People's privacy was respected. People's bedroom doors were fitted with suitable locks to help promote privacy of personal space. One staff member told us, "We are aware people share properties so we always remind them to maintain their privacy." Staff also described how they upheld people's privacy, by sensitively supporting people with their personal care needs and maintaining confidentiality of information. There was confidentiality policy which had been available to care staff. We observed staff knocked on bedroom doors before entering.

People's relatives and friends told us they were made to feel welcome and were able to visit without being unnecessarily restricted. For example we observed people moving around their environment independently with no restrictions. In some cases people had been supported to make their own meals or to assist with house chores such as vacuuming, shopping and preparing their own meals. This meant that staff had supported people to use and develop their independent living skills.

The service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. We saw staff had discussed with people their preferences and choices. Where this was not possible families and professionals had been involved. For example we saw people being consulted about where they wanted to go on holiday or what activities they wanted to be involved in. There was policy on advocacy which was made available to people and staff when they

commenced their employment. The safeguarding policy and the mental capacity policy also provided information on when staff should consider involving an advocate. In the majority of cases family had acted as advocates for their relatives. The majority of people who used the service had been supported by an advocacy service to manage their money.

Advocates support people to access information and make informed choices about various areas in their lives. Relatives we spoke with informed us that they had been more involved in the care of their family members and that this had improved the quality of the care they received. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using the service.

Good

Is the service responsive?

Our findings

People received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. People were supported to do things they enjoyed and follow their interests. Comments from people included; "When I've needed to have a discussion on something I will ask one of the staff, they have always listened and responded to what I've said." "I go shopping at the weekend. I also go swimming, gym club and to bingo." And; "I have music lessons every week, staff support me."

Relatives were equally positive and felt the service was responding to people's needs. One relative told us, "Yes they are very responsive, they have supported my [relative effectively]. They consult him about things and he attends meetings to give them feedback."

People's care records demonstrated that the service had ensured that care plans fully reflected their physical, mental, emotional and social needs. They had been developed where possible with each person, family and professionals involved with them and identified what support they required. Relatives told us they had been consulted about support that was to be provided before using the service. They told us they sat down with service managers regularly to discuss what had gone well and what could be improved in the service.

During the reviews, people's outcomes were discussed and people were given an opportunity to discuss what had gone well and what could be improved. These records were well written and person centred. The process followed was holistic and looked at the whole person. The care planning approach demonstrated how staff took into account people's strengths, their levels of independence and their quality of life. However, we found reviews had not always been consistently undertaken when they were due. We spoke to the area manager who informed us that they had identified this issue in their audits and that they had inherited the shortfalls however they had taken measures to address this.

One relative told us; "My [relative] has a care plan and they ring and tell us if there is any concerns. I also attend meetings with the directors. He is out and about with his staff and they drive him to see his partner."

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified, for example, people who required assistance with moving, people who used bedrails, personal care needs, people who were at risk of choking and people who were at risk due to their vulnerability.

Staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care records. This meant that staff had an understanding of people's needs and wishes, but also of their strengths and abilities.

People were supported to follow their interests and take part in activities that were socially and culturally

relevant and appropriate to them, including in the wider community, and where appropriate, have access to education and work opportunities. For example one person had been supported to attend football matches and follow their musical interests. The service's values and ethos ensured that people were involved in community activities; there was a positive approach to risk taking which enabled people to explore and enjoy outdoor activities. There were walks, swimming, and horse riding, among other therapeutic activities. Some people had exercise bikes in their houses which they used with support from staff to maintain their fitness.

People were encouraged and supported to develop and maintain relationships with people that mattered to them, both within the service and the wider community to avoid social isolation. For example, we saw one person who used the service had been supported to regularly maintain contact with their partner. Another person was supported to have access to church where they had developed positive relationships with other people.

One staff member told us, "We take a walk to town almost every day it's part of his routine." In addition relatives told us the provider organised family events for people, their families and staff and their families. Some of the people who used the service took a lead in organising the events such as the Christmas party. This helped to maintain continuity and reduce social exclusion for people.

The service had identified and met the information and communication needs of people with a disability or sensory loss. For example each person's care file contained a communication plan which detailed how people needed to be supported with their communication needs. These were very person centred and sensitive. For example in one person's file staff were guided on the choice of words to use to support a person. Where people had specific communication needs, these had been identified. One staff member told us; "We use a number of communication interventions. Some of these include Makaton, sign language, and visual support. As well as person centred verbal and physical communications, which are set out in their communication care plans."

Information about people was recorded clearly and respectfully, and shared with others when required. People's consent to share their information had been considered. We saw records for ensuring safe transfer to hospital or other care settings had been completed and filed in people's care records. This would be useful when people were transferred to other care settings.

The service had a complaints procedure which was made available to people and their representatives before they started to use the service. Copies were on view in the service's office. The complaints procedures had been written in an easy read format to enable people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

We spoke with people who used the service and with relatives. They told us they knew how to make a complaint if they were unhappy. They told us they would speak with the manager or their area manager who they said would listen to them. We looked at the complaints that had been received at the time of our inspection. Complaints had been dealt with in timely manner and in line with the organisation's policies and procedures. Where necessary the registered manager had contacted the complainant and discussed their concerns with them.

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example there was a policy which guided staff to

record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection of United Response-Central Lancashire Supported Living in June 2016, we found there was a failure to ensure good governance. There was also a lack of robust quality assurance and audit processes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we reviewed the actions that the provider told us they had taken to gain compliance against the breaches in regulations. We saw that significant work had taken place since our last inspection to improve governance systems and quality assurance process however; there had been a lack of effective leadership following the departure of the registered manager. This led to shortfalls in oversight on staff. We found the situation had improved following the appointment of a new area manager who was overseeing the running of the service. They had started to take actions to address the shortfalls.

There was no registered manager employed at United Response-Central Lancashire Supported Living. The registered manager had left to work in another part of the organisation. The area manager had been overseeing the running of the service. In addition another manager had been appointed to register as a registered manager.

Before this inspection we had received a notification regarding the change in leadership arrangements at the service. The evidence we found showed that the change in management at the service had impacted on the quality of care and treatment provided to people who lived at the service. For example we found evidence that after the registered manager had left, staff working in some of the properties had not received regular oversight from the service manager. Staff had not received regular supervision to monitor the care they delivered. This had led to deterioration in the quality of care provided which exposed people to poor care. We found adequate oversight had not been provided to ensure people were supported adequately to manage their finances. Although this was identified as a need; adequate support had not been provided to reduce the risk of debt or financial difficulties.

At the time of our inspection a new area manager had been in post. They had identified the shortfalls and put actions to rectify them. We found they had put a significant amount of effort to ensure the shortfalls were addressed and improvements had been made.

We recommend that the service seek support and training, for the management team, about accountability and the provision of oversight on staff.

We received positive comments from people about the organisation. Comments from people included; "The managers ask me if I am happy with everything." "This is the best company I have been with, I know the manager they help me out with my behaviour and refer me to specialist nurses" and "I am happy with staff, happy with the managers. And; "The managers, came to see me about my room, they helped me sort it out and advised me to keep it clean and tidy."

Staff we spoke with told us they felt the area manager worked with them and supported them to provide good quality care. For example, we only received positive comments from staff and relatives and they included, "I like the (manager) she is superb and has the experience to lead the staff. I feel confident when she is on; whatever you ask for is done", "There was a significant work to be completed when she first arrived, she had been working hard to rectify things." A relative said, "The service is well managed and the care of the people is paramount to the staff. The directors are visible and we can go to meet them in London or they can visit us here."

We spoke with the manager about the daily operations of the service. It was clear they understood their roles and responsibilities and had an understanding of the operation of the service. This included what was working well, areas for improvement and plans for the future. The manager was experienced and had an extensive health and social care background. They were knowledgeable and familiar with the needs of the people they supported. In addition to the manager, there were three service managers, senior support workers and office staff. In majority of the cases each person took responsibility for their role and had been provided with oversight by the manager. However, evidence we found during the inspection showed that at times this had not happened. The area manager had addressed this.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We found handovers, were used to keep staff informed of people's daily needs and any changes to people's care. Information was clearly written in people's care plan records showing what care was provided and anything that needed to be done. People's daily records were written in a respectful and dignified manner.

Staff and service user meetings were held. We confirmed this by looking at minutes taken of meetings and care files. In addition staff surveys were carried out regularly. The service analysed any comments and shared them with registered provider who had acted upon them. Feedback we saw demonstrated people and their relatives felt the service was of a good quality. We saw people and staff were consulted on the daily running of the service and any future plans.

The provider had undertaken quality assurance inspections in the service. These audits provided support with ensuring compliance and analysing information in the service such as accidents and incidents, as well as monitoring that the service was complying with regulations and quality requirements with other regulatory authorities. They also drew action plans for the service managers and monitored that these had been completed in a timely manner. The area manager met with the service managers on a monthly basis to discuss the quality of the service, progress and future plans. This also gave them the opportunity to discuss areas of concern and to share updates in requirements or any developments or changes in regulatory requirements. We found regular audits had been completed. These included medicines, the environment, care records and accidents and incidents. Any issues found on audits were acted upon and lessons learnt to improve the care the service provided.

There were strong links with the local community and the service had strengthened their relationships beyond the key organisations. There were arrangements to ensure the service and staff kept up to date with good practice. This included using technology to train staff and to share information. The service worked in partnership with other organisations to make sure they were following current practice, providing a good quality service and the people in their care were safe. These included social services, healthcare professionals including General Practitioners, learning disabilities nurses, and community mental health services. The service also worked closely with the local charity organisations to ensure people using the service had a contribution in their local community.