Turning Point

Turning Point - Hampshire

Inspection report

Suite 17 Viewpoint
Basing View
Basingstoke
Hampshire
RG21 4RG

Tel: 01256799126
Website: www.turning-point.co.uk

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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 announced inspection took place on 7, 11 and 13 September 2018.

Turning Point Hampshire provides care and support to people living in four different '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. CQC does not regulate premises used for supported living. This inspection looked at people's personal care and support. At the time of the inspection the service was supporting 10 people with their personal care needs. The service supported people living with learning disabilities, autistic spectrum disorder, physical disability, sensory impairment, older people and younger adults.

At the time of inspection the service had an interim manager who had applied to become the registered manager. 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. Prior to the completion of this report the CQC registration process had been completed and they will be referred to as the registered manager throughout this report.

The registered manager was supported by two supported living service managers who managed two supported living settings each. These settings were located in the north and south of Hampshire respectively. The services in each area were close enough to provide mutual support whenever required.

In March 2017, Turning Point Hampshire began to provide the supported living service, having taken over from another care provider. Some people and staff experienced a process where their respective contracts, either for services delivered or terms and conditions of employment, were moved from another care provider.

People, relatives, staff and professionals consistently provided feedback that this transfer initially had had a negative impact on the quality of care and support people received. In 2018 the management structure of the service was reorganised and a new management team were appointed. Feedback from people, relatives, staff and professionals consistently reported that there had been significant improvements in the quality of care people experienced and an up serge in team morale, since the appointment of the new management team.

Safeguarding professionals consistently reported there had been a significant improvement in the service performance relating to unsafe care, which was now quickly recognised and responded to effectively. When concerns had been raised the provider had carried out thorough investigations, in partnership with local safeguarding bodies.

Risks to people's safety had been identified and management plans gave staff the required guidance to

manage these risks. Staff understood people's risk assessments and the action required to keep people safe.

The management team completed regular staffing needs analyses which ensured there were always enough suitable staff deployed, with the right mix of skills to deliver care and support to meet people's needs safely. The provider completed relevant pre- employment checks to assess the suitability of prospective staff to support people using the service.

Staff managed prescribed medicines consistently and safely, and involved people and their families, where appropriate, in regular medicines reviews and risk assessments. Staff maintained high standards of cleanliness and hygiene in people's homes, which reduced the risk of infection.

Staff had completed the provider's required training, which had been refreshed regularly to keep their knowledge and skills up to date. Where people had more complex needs staff training was developed and tailored around their individual needs.

Staff applied their learning effectively in accordance with best practice, which led to good outcomes for people's care and support and promoted their quality of life. Staff training was developed and delivered to meet individual needs.

People were protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions that affect their health.

The service had clear systems and processes for referring people to external healthcare services, which were applied consistently, and had a clear strategy to maintain continuity of care and support when people transferred services.

People and relatives were involved in decisions about their health and encouraged to make choices, in line with best interest decision-making.

People's human rights were consistently protected by staff who understood the need to seek lawful consent and followed the Mental Capacity Act 2005 (MCA) legislation and guidance.

People were consistently treated with kindness and compassion, which was reflected in positive feedback from their families, friends and professionals. Staff supported people to express their views and be actively involved in making decisions about their care as far as possible. People were treated with dignity and respect and without discrimination.

Staff enabled people to carry out person-centred activities and encouraged them to maintain relationships that were important to them.

People knew how to give feedback about their experiences, including how to raise any concerns or make a complaint. The registered manager used the learning from complaints and concerns to drive improvement in the service.

People's needs assessments considered their protected equality characteristics and the accessible information standards.

Staff sensitively supported people and their families to explore and record their wishes about care at the end of their life.

The service was consistently well-managed and led. The provider had a clear vision to deliver high-quality care and support, and promote a positive culture that was person-centred and achieved good outcomes for people.

The provider's systems identified and managed risks to the quality of the service. Quality assurance arrangements were robust and identified potential concerns and areas for improvement.

The registered manager was transparent, open and honest with all relevant external stakeholders and agencies and worked collaboratively in partnership with key organisations.

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.

Staff had developed positive and trusting relationships with people that helped to keep them safe.

Staff supported people to manage risks to their safety, whilst promoting their independence.

There were enough suitably skilled staff deployed to meet people's needs safely.

People's medicines were managed safely by staff who had their competence to do so regularly assessed.

Is the service effective?

Good

The service was effective.

Staff received appropriate training, supervision and support to ensure they had the required skills and experience to enable them to meet people's needs effectively.

People were supported to make their own decisions and choices and their consent was always sought in line with legislation.

People were supported to eat a healthy, balanced diet of their choice, which met their dietary requirements.

People were supported by staff to maintain good health, had regular access to healthcare services and received on-going healthcare support when required.

Is the service caring?

Good

The service was caring.

People were consistently treated with dignity, respect and kindness.

Staff consistently treated people as individuals and quickly responded to their changing needs.

People and their relatives were actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive.

People were supported to develop and maintain relationships with people that matter to them to avoid social isolation.

The provider used feedback, concerns and complaints as an opportunity to learn and drive continuous improvement of the service.

People and their families were actively involved in planning and making decisions about their end of life care.

Is the service well-led?

Good

The service was well-led.

The management team consistently demonstrated the skills, knowledge, experience and integrity required to provide clear and direct leadership.

The registered manager encouraged open communication with people, their family, friends, staff and other stakeholders, taking account of their protected and other characteristics.

The provider had effective quality assurance processes and the registered manager monitored and reviewed the delivery of care against good practice guidance..

Turning Point - Hampshire

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 checked 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 unannounced comprehensive inspection took place on 7, 11 and 13 September 2018 and was carried out by one inspector. On 7 September 2018 we completed a site visit at the service registered office. On 11 and 13 September 2018 we completed site visits at the supported living settings in the south and north of Hampshire, respectively.

Before the inspection, we reviewed all the information we held about the service including reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. Due to CQC technical problems, the provider was not able to complete a 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 took this into account when we inspected the service and made the judgements in this report. We obtained this information during our inspection. We also reviewed information contained within the provider's website.

During our inspection we spoke with four people using the service, who had limited verbal communication, and six relatives. We used a range of different methods to help us understand the experiences of people using the service, who were not always able to tell us about their experience. These included observations and pathway tracking. Pathway tracking is a process which enables us to look in detail at the care received by an individual in the home. We pathway tracked the care of six people.

Throughout the inspection we observed how staff interacted and cared for people across the course of the day, including mealtimes, during activities and when medicines were administered. We spoke with the registered manager, the provider's locality manager, quality contract manager and 17 members of staff, which included five agency and one bank staff.

We reviewed ten people's care records, which included their daily notes, care plans and medicine administration records (MARs). We looked at ten staff recruitment, supervision and training files. We examined the provider's records which demonstrated how people's care reviews, staff supervisions, appraisals and required training were arranged.

We also looked at the provider's policies and procedures and other records relating to the management of the service, such as staff rotas covering August and September 2018, health and safety audits, medicine management audits, infection control audits, the service improvement plan, emergency contingency plans and minutes of staff meetings. We considered how people's, relatives' and staff comments were used to drive improvements in the service.

Following our visit, we obtained feedback from twelve health and social care professionals who had engaged with the service in the previous year regarding the quality of care people received.

This was the first inspection of this service.

Good

Is the service safe?

Our findings

People experienced care that met their needs and made them feel safe. Staff had developed meaningful and trusting relationships with people that helped to keep them safe. People's families and representatives consistently told us their loved ones were safe. One relative told us, "[Named family member receives, "Good quality care which keeps her safe, from carers who are warm and friendly but professional." Another relative told us, "We have no worries because all of the carers have everyone's best interests at heart and go out of their way to make sure they get the best possible care." Another relative told us their loved one was, "Very safe because all of the carers know her so well and respond quickly if she is unwell or unhappy."

People were consistently protected from avoidable harm, neglect, abuse and discrimination. Staff had completed the provider's required training and understood their responsibilities to safeguard people. Staff could explain how they ensured the human rights of people who lacked a voice were upheld and respected.

Staff performance relating to unsafe care was recognised and responded to effectively. Lessons learned were shared and applied in practice. When concerns had been raised, for example; delays in seeking healthcare support, the provider had carried out thorough investigations, in partnership with local safeguarding bodies.

The provider had appropriately notified five safeguarding incidents in 2017. Health and social care professionals involved in these investigations commended the provider for being open and transparent in relation to the identified concerns. Relevant professionals consistently told us that the required improvements had been made and people now experienced safe, quality care.

Risks to people's safety had been identified and management plans had been created, which gave staff the required guidance about how to mitigate these risks. Where people were subject to restrictions to reassure and keep them safe, these were minimised to promote people's freedom. For example, supporting people to access the community and engage in physical activities safely, by managing associated risks effectively.

Staff understood people's risk assessments and the action required to keep people safe. Throughout our inspection we observed staff deliver care in accordance with people's risk assessments, which kept them safe and met their individual needs.

Staff shared information about risks consistently and accurately during shift handovers, staff meetings and one-to-one supervision, to ensure they were managed safely. During daily shift handovers we observed staff review people's changing needs and discuss action required to manage any increased risks.

People were protected from harm because staff understood the provider's safety systems, policies and procedures. Each person had an individual dependency assessment, which detailed the level of staff support required to keep them safe in any situation. These assessments specified the ratio of staff required to support each person. The registered manager and supported living service managers completed daily staffing needs analyses based on the dependency of the individuals being supported. This ensured there

were always enough staff deployed, with the right mix of skills to deliver care and support to meet people's needs safely and to respond to any unforeseen events.

Staff had undergone relevant pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective staff underwent a practical role related interview before being appointed. People were safe as they were cared for by sufficient staff whose suitability for their role had been assessed by the provider.

The provider had systems and processes in place to ensure medicines were managed safely in accordance with current guidance and regulations. Designated staff had their competency to administer medicines assessed regularly by the provider's clinical lead, to ensure their practice was safe, in line with guidance issued by the National Institute for Health and Care Excellence.

Staff had followed correct procedures to protect people with limited capacity to make decisions about their own care, treatment and support, when medicines needed to be given without their knowledge or consent, or when people required specialist medication.

There were appropriate systems to ensure the safe storage and disposal of medicines and additional security for specified medicines required by legislation. We observed staff supporting people to take their medicines by their chosen method, in a safe and respectful way, in accordance with their medicines management plans.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff reviewed each other's MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistake was found, to ensure people were protected. People's MAR's had been correctly signed by staff to record when their medicine had been administered and the dose. Where people were prescribed medicines, there was evidence within their medicines management plan that regular reviews were completed to ensure continued administration was still required to meet their needs. Where people took medicines 'As required (PRN)' there was guidance for staff about their use. These are medicines which people take only when needed.

Staff managed medicines consistently and safely, and involved people and their families where appropriate in regular medicines reviews and risk assessments.

We observed staff maintain high standards of cleanliness and hygiene in people's homes, which reduced the risk of infection. All staff clearly understood the provider's policies and procedures about infection control, which were up to date and based on relevant national guidance. Staff had completed relevant training in relation to infection control and food hygiene. We observed staff followed required standards of food safety and hygiene, when preparing or handling food.

Good

Is the service effective?

Our findings

Staff told us they had received a thorough induction that provided them with the skills and confidence to carry out their role effectively. The provider had reviewed the induction programme to link it to the Care Certificate. The Care Certificate sets out national outcomes, competences and standards of care that care workers are expected to achieve. Staff also worked with experienced staff to learn people's specific care needs and how to support them before they were authorised to work unsupervised. New staff were not allowed to work unsupervised until they were confident to do so and the registered manager had assessed their competence. This ensured staff had the appropriate knowledge and skills to support people effectively. A new member of staff told us, "My induction has been fantastic. There was a lot to learn but the managers and other staff are really supportive and make you feel you can go to any of them for advice and help if you're worried or not sure about something."

Records demonstrated staff had completed the provider's required training and that this had been refreshed regularly to keep their knowledge and skills up to date. Where people had more complex needs staff training was developed and tailored around their individual needs, for example; Staff supported some people who were at risk of choking to receive nutrition and medicines through a peg tube. Percutaneous endoscopic gastrostomy (PEG) is a medical procedure, in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Other people were supported with a nasogastric intubation whereby people who had trouble eating and drinking were supported via a soft tube, which passed from their nose into their stomach. The most common purpose for inserting a nasogastric tube is to deliver nutrition and hydration to a person when they are unable to eat and drink.

The registered manager had established effective links with the community nursing team and were devising further staff training to support people's assessed needs, for example; in relation to supporting people to manage their diabetes, epilepsy and bowel care.

Supervision and appraisal were used to develop and motivate staff, review their practice and focus on professional development. Records confirmed that staff had one-to-one regular meetings with their designated line manager. Most staff told us they received effective supervision, appraisal, training and support to carry out their roles and responsibilities. Most staff told us that they were well supported by the management team and were encouraged to speak with them immediately if they had concerns about anything, particularly in relation to people's needs. However, two staff members thought that prior to the appointment of the new locality manager, registered manager and supported living managers they had not been effectively supported through the transition from the previous provider. Most staff told us the new management team listened to their ideas and felt their contributions were valued and acted upon, for example; suggestions for people to take part in new activities.

The registered manager had ensured people's ability to make decisions was assessed in line with the Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager had completed a review of previous decisions made in relation to individuals who were being supported with potentially restrictive equipment. Records demonstrated the registered manager had established an effective best interests decision process which ensured people's human rights were protected.

We observed staff consistently seeking consent from people using simple questions and giving them time to respond. Staff supported people to make as many decisions as possible. People's human rights were protected by staff who demonstrated a clear understanding of the need to seek lawful consent and MCA legislation and guidance.

Staff had consulted with relatives and healthcare professionals and had documented decisions taken, including why they were in the person's best interests. For example, decisions had been made on behalf of people who would prefer to remain at home to continue their care if their health deteriorated. The registered manager effectively operated a process of mental capacity assessment and best interest decisions, which aligned with the principles of MCA. .

Some people had appointed family members as their Power of Attorney (POA) which empowered them to act on their behalf, whilst others had an independent advocate. The registered manager and supported living managers had reviewed records to ensure they accurately reflected who should be consulted in relation to specific decisions.

People received support which achieved their desired outcomes and promoted a good quality of life, based on the best available evidence. Relatives consistently praised the skill and expertise of the staff in meeting people's complex and emotional needs. Relatives and professionals told us staff understood people's needs and knew how they wished to be supported. We observed staff consistently delivered care in accordance with their assessed needs and guidance contained within their care plans. One relative told us, "The carers are really good, they know what they're doing and you cannot fault their dedication to [loved one]. We were worried when Turning Point first came in and there were a few teething problems but in the last six months, under the new managers, there has been a great improvement."

People were protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions because staff followed guidance from relevant dietetic professionals. Where required regular monitoring and review by relevant professionals ensured people's nutritional needs were met.

We observed mealtimes were unhurried and arranged to suit individual needs and preferences. For example, people were offered choices of their favourite meals, such as chicken soup and bread or pasta. Staff understood the different strategies to encourage and support people to eat a healthy diet. For example, some people were being supported to gain and maintain weight, whilst others were being supported lose weight, in accordance with relevant professional guidance.

Each person had an individual health action plan which detailed the completion of important monthly health checks. The manager consistently applied processes for referring people to external services such as GPs, community nurses, specialist nurses, dieticians, opticians and dentists, which maintained their health. The supported living service managers operated effective communication systems to ensure all appointments and information in relation to people's care and treatment was shared efficiently with staff.

For example, updating the results of medical examinations and changes to people's medicine prescriptions. During our inspection people were being supported with medical procedures in accordance with their health plans, for example the provision of blood tests.

Professionals told us that since concerns had been raised in 2017 prompt referrals to them were now made by the provider to ensure that people's changing needs were met by staff, who effectively implemented their guidance. There were clear systems and processes for referring people to external healthcare services, which were applied consistently. A clear strategy was in place to maintain continuity of care and support when people transferred services, for example; whenever people were admitted to hospital they were always accompanied by staff until they were discharged.

People and their representatives were involved in decisions about the decoration of their personal rooms, which met their personal and cultural needs and preferences. People's homes had been adapted to meet their needs and to accommodate individual specialised supportive equipment.

Good

Is the service caring?

Our findings

Relatives and professionals consistently made positive comments about the caring attitude of the staff. One relative told us, "The carers are out of this world and treat everyone here like their own family." Another relative told us, "The thing that makes this service special is the bond between the carers and everyone they care for. You can see it and feel it all around you." A professional told us, "People are supported by caring staff who want what is best for them. The love and care of the staff has never been in question but there is now more guidance and direction."

Staff spoke about people fondly, recognising their achievements with pride and passion, which demonstrated how they valued them as individuals. Relatives praised the dedicated, caring nature of staff, which had enabled their loved ones to have the opportunity to lead an independent fulfilling life. One family member told us, "The caring staff is the key. They just want what is best for [their loved one] and will do anything to make her happy."

Staff were caring and treated people with respect at all times. Relatives consistently told us this went a long way to gaining people's trust and made them feel 'wanted'. Families and representatives of people consistently told us that staff had developed special bonds with their loved ones.

Staff anticipated people's needs and quickly recognised if they were in distress or discomfort. We observed staff consistently show concern for people's wellbeing in a caring and meaningful way, whilst responding promptly to their needs. For example, when people experienced pain.

The registered manager and staff had cultivated a caring community within the supported living services, where staff, people and relatives treated one another with respect and empathy. Relatives consistently reported the registered manager and staff had invested time developing caring and trusting relationships with their loved one and their families. New members of staff told us more experienced colleagues were excellent role models and supported them to develop their own relationships with people. People experienced positive relationships with staff who worked as a team to develop people's trust and confidence.

We observed staff deliver people's care in a calm unhurried manner, which inspired confidence and reassured them. Staff clearly understood people's non-verbal communication systems and continually engaged people in two-way conversations about things that were important to them, such as their families, which made them feel valued. Staff spoke with affection about people, their life stories, their likes and dislikes, as well as their care and support needs. Family members consistently told us that staff always made time to sit and have a chat with them and their loved ones.

Staff told us about their special memories whilst working for Turning Point, which frequently described small steps taken by individuals. One staff member proudly told us how they had developed caring relationships with people, which enabled them to recognise their non-verbal communication signs. One staff member became tearful and told us, "She talks with her eyes. I will never forget the moment she smiled

at me with her sparkling eyes, when we were listening to 'you're beautiful just the way you are.' She was so beautiful and it makes you feel special when you make a connection like that."

The registered manager completed rotas and implemented other practical arrangements to enable staff to have the time to listen to people and their families and involve them in their care decisions. People's emotional needs were understood and supported by compassionate staff. For example, on the first day of our inspection staff had arranged the preferred representative from a person's circle of trust to accompany them for a blood test.

People's care records included an assessment of their needs in relation to equality and diversity. Staff underwent training and understood their role to ensure people's diverse needs and right to equality were met. The registered manager and supported living managers completed supervisions and competency assessments to ensure people experienced care which respected their privacy and dignity, whilst protecting their human rights.

Staff told us it was important to enable people to remain independent and clearly understood people's individual needs around privacy and dignity, which we observed in practice. People and relatives, where appropriate, were actively involved in making decisions and planning their own care and support.

People experienced care from staff who understood the importance of respecting people's privacy and dignity, particularly when supporting them with personal care. People's privacy and dignity was maintained by staff, for example; by keeping their doors closed whilst supporting them with personal care and explaining what they were doing throughout.

Where people had specific or complex requirements, in relation to their individual communication needs, these were embraced and delivered by staff in a caring manner. Where people had limited verbal communication staff ensured they were provided with explanations in accordance with their care plans, which we observed in practice. For example, when required, staff spoke slowly and clearly, allowing people time to understand what was happening and to make decisions.

Care plans demonstrated that people and relatives, where appropriate, were involved in the planning and reviewing of their care. This was confirmed by relatives and professionals, who consistently told us they experienced good communication with staff who kept them fully informed and involved in the care review process. Care plans detailed clear instructions for staff to ensure people were supported to make choices about their individual care, for example; choices in relation to their clothing, meals and drinks. Staff told us that care plans had improved significantly in the last six months, which was confirmed by visiting professionals.

Staff respected people's right to refuse care, which we observed in practice. People told us that staff also exercised their duty of care in circumstances where their refusal to do something could adversely affect their health, for example; if they chose not to take their prescribed medicine or to eat and drink.

Confidentiality, dignity and respect formed a key part of the induction training for all staff. Confidential information, such as care records and staff files, were kept securely within the supported living manager's office and only accessed by staff authorised to view it.

Good

Is the service responsive?

Our findings

Relatives consistently told us people experienced care that was flexible and responsive to their individual needs and preferences. Care plans were person centred and fully reflected people's physical, emotional and social needs. Staff told us care plans contained detailed guidance that clearly identified how people's assessed needs were to be met. Plans had been reviewed and updated regularly which ensured staff were enabled to meet and respond to people's changing needs and wishes.

Care plans were centred on the needs of each person including information about people's health needs, medicines; continence; skin integrity; nutrition; and mobility. Staff clearly understood people's needs and how they wished to receive care and support.

People's daily records of care were up to date and showed care was being provided to meet their needs, in accordance with their care plans. Staff were able to describe the care and support required by each person. For example; staff knew which people needed support to be re-positioned regularly and those who needed encouragement to eat.

People's changing care needs were identified promptly and were referred to relevant professionals when required, for example; when people had developed chest and other infections. Where aspects of people's health were being monitored, records demonstrated that staff responded quickly when required. For example, staff took appropriate action in response to pressure area management. We observed changes to people's care were discussed at shift handovers to ensure staff were responding to people's current care and support needs.

People and those lawfully authorised to act on their behalf, were fully involved in the planning of their care and support. Relatives, care managers and commissioners of people's care consistently told us the registered manager and staff ensured individuals were enabled to have as much choice and control as possible.

Staff demonstrated a clear understanding of their responsibility to consider people's needs on the grounds of protected equality characteristics, as part of the planning process and provisions had been made to support each individual. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. These are now called `protected characteristics'. Care plans showed people's individual religious beliefs and preferences had been considered. For example, one person was supported to regularly attend their preferred place of worship, to promote their spiritual well-being.

Staff supported people to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. Staff were risk aware and promoted people's safe participation in stimulating and therapeutic activities, including carriage riding and hydrotherapy. When people participated in activities, staff completed assessments and analysis of the impact of the activity on their well-being.

People were enabled to be as independent as they could be and were supported to maintain their independence and life skills, for example; completing their personal care and grooming.

Staff actively encouraged social contact and companionship and supported people to maintain relationships that mattered to them, such as family, community and other social links. For example, staff supported the development of friendships between the people living in the different supported living settings, through social gatherings, such as barbeques and parties, attendance at day centres and social clubs. People were recently supported by staff to host a coffee morning in support of a well- known cancer charity. We reviewed photographs celebrating this event in the service "People's Parliament" newsletter. People were protected from the risk of social isolation and loneliness, by staff communicating and working effectively in partnership with families and representatives.

Relatives consistently told us that the companionship their loved ones enjoyed with staff was often more important and beneficial to them than the physical support they provided. Staff told us they were committed to ensure people did not feel lonely and were protected from the risks associated with social isolation, which we observed in practice.

There were regular opportunities for people and staff to feed back any concerns at review meetings, staff meetings and supervision meetings. Records showed these were open discussions. The provider completed regular satisfaction surveys and held quarterly forums for people, families and staff. Feedback from people and staff was analysed and action taken to improve the service. The results and providers action was fed back to people, relatives and staff in newsletter and monthly updates called "You said..We did." Feedback was consistently positive, with many complimentary comments about the support provided, the staff and the overall service.

People and their relatives knew how to complain. The provider's complaints policy and procedure was prominently displayed within the home. People and relatives told us if they had a complaint they would raise it with the registered manager and were confident action would be taken to address their concerns. Relatives told us the management team made a point of speaking with them when they visited to make sure their loved one was happy and whether there was anything they could do improve their quality of life. Staff were aware of the provider's complaints policy but consistently told us the registered manager encouraged them to use their initiative and proactively resolve problems as soon as they were raised to prevent them escalating.

The registered manager valued concerns and complaints as an opportunity for driving improvement within the service. Where complaints highlighted areas of required learning and improvement the registered manager had taken positive action, for example; ensuring staff underwent further training when poor practice had been identified.

At the time of inspection no-one living in the supported living settings required end of life care. However, advanced care plans were developed with people and their families. These ensured people's end of life choices and preferences were known and documented, for example; the person's preferred place of death and who they wished to make decisions on their behalf. Relatives told us that staff were empathetic with family and friends and consistently discussed advanced decisions with them, where appropriate, in a compassionate and sensitive manner.

The service ensured that people and their representatives had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework making it a legal requirement for all providers to ensure people with a

disability or sensory loss can access and understand information they are given. For example, we reviewed the comprehensive communication plan of a person who experienced profound sensory loss, which provided staff with clear guidance to meet this standard.

Good

Is the service well-led?

Our findings

In March 2017, Turning Point Hampshire began to provide a supported living service at four locations in Hampshire, having taken over from another care provider. Some people and staff experienced a process where their respective contracts, either for services delivered or terms and conditions of employment, were moved from another care provider.

People, relatives, staff and professionals consistently provided feedback that this transfer initially had had a negative impact on the quality of care and support people received. In 2018 the management structure of the service has been changed with a new locality (area) manager, registered manager and supported living service managers being appointed. Feedback from people, relatives, staff and professionals consistently reported that significant improvements had been made to the quality of care provided and morale of staff, since the appointment of the new management team.

Relatives, staff and professionals consistently told us the service was well managed. One relative told us, "There were a few problems when the new company took over last year, which weren't helped because of the quick turnover of managers, but things are much better now. The new managers are really good. They listen and then take action to sort things out." Another relative told us, "The new managers [named registered manager, supported living service manager, locality manager] are very good, they are always available and very supportive. They have really got everyone pulling together." Professionals consistently reported that the service had significantly improved under the new management team, who had listened to and effectively implemented their guidance.

People and their relatives consistently told us that they trusted the registered manager and their management team and felt confident to express their views and concerns. Families consistently made positive comments about the registered manager and staff's devotion to people. One relative told us, "[Named supported living service manager] is very caring but very organised. They know where they are going and how to get there." Another relative told us, "Things are much better because there is some stability from the managers who have improved the team spirit."

Relatives and staff who had experienced the transfer process, particularly praised the new registered manager and their team, for the way they had kept them informed and reassured them about the future.

The provider and management team had created an open, inclusive, person-centred culture, which achieved good outcomes for people, based on the provider's values. These values focussed on treating people as individuals, with dignity and respect, whilst promoting their independence.

Staff consistently told us the management team had created a supportive environment where their opinions and views were discussed and taken seriously, which made them feel their contributions were valued. One member of staff told us, "At last we've got some managers and know who we need to go to if something needs sorting out or if we need help and support." Another staff member told us, "It's good that we've now got a highly visible manager who is at the home [supported living service] regularly and comes straight away

if you need them."

There was a clear management structure within the service. Staff understood their roles and responsibilities and had confidence in the management team who frequently worked alongside them and provided constructive feedback about their performance. Staff reported that the new management team readily recognised and thanked them for their good work. Rotas demonstrated there was always a designated manager available out of hours.

Throughout our inspection we observed the registered manager and their supported living service managers consistently provide clear and direct leadership in relation to unexpected events, for example; provision of resources in relation to unexpected staff absence and appropriate guidance in relation to a change in a person's needs.

Relatives and staff told us they were fully supported by the registered manager whenever they raised concerns or sensitive issues. The registered manager dealt with the issues promptly, in an open and transparent manner.

The provider had suitable arrangements to support the registered manager, for example through regular meetings, which also formed part of their quality assurance process. The registered manager told us they had received excellent support from the provider's locality manager since their appointment.

Professionals and commissioners consistently told us the service was now well organised and they experienced good communication with the management team and staff who were always open and honest. Relatives told us they experienced good communication with the management team and staff always knew what was happening in relation to their family member whenever they called or visited.

Quality assurance systems were in place to monitor the quality of service being delivered, which were effectively operated by the management team. Staff completed a series of quality audits including care files, health and safety, fire management and maintenance. Action plans were developed following each audit and monitored to drive the continuous development and improvement of the service, for example; the registered manager and supported living services were in the process of updating all care plans to make them more person centred.

The provider and registered manager undertook unannounced quality and compliance visits in addition to spot checks during the night to assess whether staff were working effectively. The provider sought feedback to improve the service using a variety of different methods. People and their families told us they were given the opportunity to provide feedback about the culture and development of the service in residents' forums. Relatives had been impressed with the provider's willingness to listen to their concerns and how quickly they acted upon them.

The provider ensured that best practice was shared and acted on throughout the service and the registered manager measured and reviewed the delivery of care against good practice guidance. For example, the registered manager shared the provider's monthly "Team Brief" with staff, which highlighted good practice examples and initiatives across the care group in support of people living with a learning disability or mental health diagnoses.

Accidents and incidents were effectively logged by staff and reviewed by designated managers. This ensured the provider's accountability to identify trends and manage actions appropriately to reduce the risk of repeated incidents was fulfilled. The provider had effective systems, which supported the reviews and

monitoring of actions, to ensure identified and required improvements to people's care were implemented.

The registered manager collaborated effectively with key organisations and agencies to support care provision, service development and joined-up care. For example, there was close liaison with respective community nursing teams, nursing specialists, and relevant health and social care professionals.