The Regard Partnership Limited

Domiciliary Care Agency Kent and Sussex

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 19 April and 02 May 2018 and was announced.

This service provides personal care and support to adults living in 'supported living' settings, so that they can live 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. This supported living service meets the needs of people who have mental health needs, a learning disability or autistic spectrum disorder and people who have a physical disability. Not everybody using the service received the Regulated activity of personal care. At the time of this inspection there were ten people receiving personal care. The service is run from an office in Rochester in Kent.

A registered manager was employed at the service and they were present during the inspection. 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.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. People told us they felt safe with staff. Information was shared with people who used the service in different formats such as pictures and one to one conversations about how to raise concerns and protect themselves from potential abuse and bullying.

Staff assessed and treated people as individuals so that they understood how they planned people's care to maintain their safety, health and wellbeing and choices. Risks were assessed within the service, both to individual people and for the wider risk from the environment people lived in. Actions to minimise risks were recorded.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. Staff understood the steps they should take to minimise risks when they were identified. The provider's health and safety policies and management plans were implemented by staff to protect people from harm.

Staff were trained about the safe management of people with behaviours that may harm themselves or others.

The registered manager involved people in planning their care by assessing their needs based on a person centred approach. We observed and people described a service that was welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered. People could involve relatives or others who were important to them when

they chose the care they wanted.

The person centred care plans developed to assist staff to meet people's needs told people's life story, recorded who the important relatives and friends were in people's lives and explained what lifestyle choices people had made. Care planning told staff what people could do independently, what skills people wanted to develop and what staff needed to help people to do.

People were often asked if they were happy with the care they received. The provider offered an inclusive service. The culture of the service was underpinned by nationally recognised standards called REACH. (The eleven REACH standards set out what people should expect, as equal citizens, from their staff team or agency offering them support.) The service also had policies about Equality, Diversity and Human Rights. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, or by using formal feedback forms.

The registered manager had experience of managing supported living services. The registered manager spent time at each service. This meant that the registered manager had an in depth knowledge of how the service was running and got to know people and staff very well. The registered manager and the provider had demonstrated a desire to improve the quality of the service for people by listening to feedback, asking people their views and improving how the service was delivered.

The registered manager and staff followed the Mental Capacity Act 2005 (MCA). The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA). Staff received training about this.

Safe recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The provider recruited staff with relevant experience and the right attitude to work with people who had learning disabilities.

New staff and existing staff were given an induction and on-going training which included information specific to the people's needs in the service. Staff were deployed in a planned way, with the correct training, skills and experience to meet people's needs. Staff received supervision and attended meetings that assisted them in maintaining their skills and knowledge of social care.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink. Staff supported people to maintain a balanced diet and monitor their nutritional health.

There were policies and procedures in place for the safe administration of medicines. People had control over their medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health.

People and staff felt that the service was well led. They told us that the registered manager, understood people's needs, was approachable and listened to their views. The provider and registered manager continued to develop business plans to improve the service.

The quality outcomes promoted in the providers policies and procedures were monitored by the

management in the service. Audits undertaken were based on cause and effect learning analysis, to improve quality. Staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice.

Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and had access to personal protective equipment like disposable gloves and apron's.

Working in community settings staff often had to work on their own, but they were provided with good support and an 'Outside Office Hours' number to call during evenings and at weekends if they had concerns about people. The service could continue to run in the event of emergencies arising so that people's care would continue.

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 experienced a service that made them feel safe.

Individualised and general risks were assessed to minimise potential harm.

Staff knew what they should do to identify and raise safeguarding concerns. Management understood how to report safeguarding concerns and notified the appropriate agencies.

The provider used safe recruitment procedures and general and individual risks were assessed. Medicines were managed and administered safely.

Incidents and accidents were investigated and monitored to reduce risk.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink to maintain their health and wellbeing.

Staff met with their managers to discuss their work performance and staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 was understood by the management and staff received training about this.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff provided care to people as individuals. People were provided with the care they needed, based on a care plan about them.

People could take part in activities and socialise according to their lifestyle choices.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The provider operated systems and policies that focused on the quality of service delivery.

There were localised management structures in place to monitor and review the risks and quality improvement opportunities that may present themselves as the service was delivered.

Staff received training about the provider's values and culture to enable them to meet people's lifestyle choices in a person centred way.

Staff understood they were accountable for the quality of the care they delivered.

Domiciliary Care Agency Kent and Sussex

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 announced inspection started at the provider's office in Rochester on 19 April 2018 and we carried out home visits on 02 May 2018. The inspection was carried out by one inspector. We gave the service 48 hours' notice of the inspection visit because we needed the registered manager to be available to interview at the office. We also needed to gather some pre inspection information to confirm which people had consented to us visiting them at their home.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Five people told us about their experience of the service. Two people gave us their views via a feedback questionnaire. We spoke with three staff, including the registered manager, and two care workers. We received feedback about the service via a feedback questionnaire from thirteen staff and one relative.

We looked at records held by the provider and care records held in the office. This included three people's care plans and the recruitment records of four staff employed at the service and the staff training programme. With consent, we looked at three people's care plans when we visited them at home. We viewed a range of policies; medicines management; complaints and compliments; meetings minutes; health and safety assessments and quality audits.

The service had been registered with us since 05 May 2017. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe with staff and protected from abuse. One person said, "I like all the staff, they are very good." Another person said, "The staff are good at helping with my medicines, they are always on time."

People were safeguarded by staff who were trained to protect people from harm. Staff followed the provider's policy about safeguarding people and this policy was up to date with current practice. Staff had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff had read and understood the provider's whistleblowing policy.

Staff understood their responsibilities to report concerns. A member of staff said, "We get good training about safeguarding." Another member of staff said, "Staff know each other really well, I trust my colleagues, we share information and get training in areas of safety such as risks assessment and first aid training." Staff we spoke with gave us clear details of how they look out for and report concerns, both internally and if needed by blowing the whistle externally. Staff gave examples of what they would look out for, such as changes in people's behaviours, routines, medicines not being taken or physical signs of harm like bruising. All of the staff who responded to our questionnaires understood how to protect people from harm. The proper management of risk and support people received from staff reduced the risks of harm.

People were protected from harm through assessments and open and transparent risks management processes. The registered manager understood how to protect people by reporting concerns they had to the local authority care managers. Staff encouraged people to attend their regular care review meetings and medicine reviews. People had been assessed to see if they were at any risks from their behaviours and mental illness. The risk, challenges and vulnerabilities people faced changed from day to day and this was taken into account by the registered manager. For example, if people felt unwell or displayed behaviours that may challenge others the care was adapted. As the risks to people increased, the staff interventions increased as well to ensure people's mental health remained as stable as possible. For example, if people became unwell and harmed themselves or others. Where risk had been identified, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety at times when their behaviours got worse. For example, if people became more vulnerable in their local community due to changes in their behaviours. Assessing the risks individual people may be exposed to and taking action to minimise this helped people stay safer.

There had been five recorded safeguarding notifications since the service had registered. These had been appropriately reported and investigated under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse). The registered manager and staff had taken steps to minimise risk of safeguarding incidents by working closely with people and their care manager. For example, people had been provided with equipment, like non slip mats to reduce the risks of incidents reoccurring and staff received specialised behavioural management training.

There were systems in place to monitor and collate incident and accident data to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. Risks were reduced by consensus and with respect to people's independence. The records showed that management were investigating and reviewing the reports and monitoring for any potential concerns. This ensured that risks were minimised across the service and that safe working practices were followed by staff.

Risks to people's individual health and wellbeing were assessed. Each person's care plan contained individual risk assessments including assessments of people's specific care needs, diet and hydration and communication. For example, where people had epilepsy, risk assessments were in place to minimise harm. Care managers were involved in planning and reviewing people's wellbeing. Where risks were identified, people's care plans described the actions care staff should take to minimise the risks. Staff signed support plans and risk assessments to acknowledge that they understood them. When we spoke with staff they confirmed they understood potential risks and how these were minimised. Risks were discussed, communicated within the team and recorded at staff handover meetings and in team meetings. Records detailed the information shared between staff about risks within the service. This meant that the risks people may be exposed to were minimised.

Staff with the right skills supported people in the right numbers to be able to deliver care safely. Staff were experienced in caring for people with learning disabilities and complex needs. Staff turnover was low in the service which meant that staff had got to know the people they were supporting very well. People were independent with areas of their life skills and staff were not required by people all of the time. We could see that the way staff were deployed matched people's needs in their care plans. The staff duty rotas demonstrated how staff were allocated to each persons support needs. We reviewed the rotas, which showed that the required number of staff were consistently deployed. The rotas supported that there were sufficient staff on shift at all times.

Planned and unexpected staff absences were managed to provide consistent levels of staff availability. If a member of staff telephones in sick, the person in charge would ring around the other staff to find cover. Managers based at the services made themselves available to cover shifts and were on the staff rota. This showed that arrangements were in place to ensure enough staff were made available at short notice. We saw that there were enough staff to supervise people and keep them safe.

People were protected from the risk of receiving care from unsuitable staff. New staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

People were protected from the risks associated with the management of medicines. Staff followed the provider's policy on the administration of medicines which had been reviewed and was up to date. People were assessed to see if they could manage their own medicines in line with their individual rights. This was supported by recorded audits carried out by trained staff and by external pharmacists. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. Staff who assisted people to administer medicines, for example by prompting, received regular training, competency checks and medicines training updates. Staff understood how to keep people safe when administering medicines. There was a policy

about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. There were systems in place so that medicines were available as prescribed. The system of medicines administration records (MAR) allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by staff when people had taken their medicine. We sampled the MAR records and these had been completed correctly. This meant that people's health and wellbeing was being maintained through the appropriate use of prescribed medicines.

The registered manager assessed risks to the environments people lived in to protect them and staff from potential hazards. Essential supplies such as the water, gas and electricity were the responsibility of the premises landlord, but the registered manager checked that the premises were kept well maintained and that people had access to a list of maintenance companies they could call if things went wrong. People were involved in choosing how their home was decorated. The registered manager liaised with the housing provider to make sure works they were accountable for were completed. Responding to maintenance issues protected people from environmental risks.

In this supported living service, staff checked the fire alarm systems and assessed people's abilities to respond to evacuation drills. Records showed that safe systems of work had been implemented via regular health and safety checks of people's home. The registered manager had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. There was an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. People who faced additional risks if they needed to evacuate had a personal emergency evacuation plan written to meet their needs. People and staff received training in how to respond to emergencies and fire practice drills were in operation. The fire procedures were in pictorial form to aid people's understanding. One person said, "I would go out [of the building] if there is a fire." People spoke to us about their understanding of fire safety. Records showed fire safety equipment was regularly checked and serviced. Assessing and reducing risks to people from foreseeable emergencies protected people from potential harm.

People were protected from potential cross infection. The premises we visited looked clean and staff received infection control training. Staff had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

People told us that the information they get about the service is clear and that the staff understood how to support them. One person said, "The staff are good, I can ask them for help." Another person said, "I can decide what I want to eat." We observed the relationship between staff and people when they were communicating. People smiled and communicated with staff in a relaxed and familiar way. We observed that staff had built trust and confidence with people to put them at ease. For example, one person wanted to make us tea and offer biscuits, which staff assisted them to achieve. This made the person less anxious when they met us during the inspection.

There was an initial assessment process in place for people before they moved into the service. The assessment captured the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. Records showed that local authority care managers were involved in the planning and review of people's care and needs. The levels of staff time people received depended on their levels of independence. The registered manager kept people's dependency levels under review to capture changes in people's care needs and levels independence. This meant that more staff hours could be deployed if people's needs increased for short periods. The assessment processes involved people and their family members in the assessment process when this was appropriate. Capturing information about people was an evolving process.

The initial needs assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist, and the community mental health team. People accessed a range of health and wellbeing services. For example, dental care.

People were encouraged to manage their health through healthy eating. Staff were helping people to do this through assisting them to prepare meals, we found that people were involved in choosing what they ate and drank and how they cooked their meals. People were happy with the support they got from staff with healthy eating. One person said, "I like making sandwiches, have salads and fruit." Where people's wellbeing was at risk from not eating and drinking healthily, plans were in place to monitor and respond to the risks.

People benefited from staff who had appropriate training and skills to meet their needs. New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Staff confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations

to check staff met the necessary standards to work safely unsupervised.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The staff on shift told us they had received training to carry out their roles. Records showed staff had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Much of the training undertaken by staff was face to face training rather than computerised courses. Staff benefited from this type of training as they could ask questions to clarify their learning. Staff received additional specialised training about learning disabilities, autism, epilepsy, mental health and how to support a person centred culture. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. Receiving training based on people's needs improved people's experiences of the care they received.

The registered manager checked how staff were performing through an established programme of staff management meetings, team meetings and formal supervision. These were staff one to one meetings and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the deputy manager was monitoring. The registered manager received records from local managers via a computerised management system so that they were aware of events and meetings that had taken place at a local level. All of the staff who fed back to us told us they received training and supervision. This meant that staff were kept up to date with current practice in social care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training in relation to protecting people's rights. This prepared them for any situation where they may think the Mental Capacity Act (MCA) 2005 needed to be considered as part of someone's care.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. This meant that staff understood how to maintain people's individuality and respect choice.

Good

Is the service caring?

Our findings

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. People told us that staff were kind, friendly and respectful and they felt included. One person said, "The staff go through my care plan with me." All of the people who responded to our questionnaire told us they felt involved in the planning of their care. We could see people had made their own notes in their care plans about their care. Care plans followed recognised person centred approaches, included photographs, pictures and captured people's life aspirations and achievements.

People living with disabilities often suffer discrimination. The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights (EDHR). These were accessible to staff and EDHR choices were included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. Staff we spoke with demonstrated to us how they delivered care respectfully. This meant that care was open and inclusive.

The care people received was person centred and met their most up to date needs. People's likes and dislikes had been recorded in their care plans. We could see who people were, what their hobbies were, what their cultural choices were and how they were being supported to meet these. For example, where people expressed a desire to live as a different gender, they were supported to do this. Staff encouraged people to be as independent as possible. People with physical disabilities had access to equipment to help them maintain their independence. For example, one person had specialised kitchen equipment to enable them to independently peel potatoes. We heard friendly and positive communication between staff and people, and observed staff to be friendly and caring. Best interest meetings about important decisions were recorded. People with changing capacity to make day-to-day decisions about their care were still offered choice and provided with information to help them decide what they wanted to do.

Staff we spoke with saw their roles as enablers for people. Staff told us about how they assisted and encouraged independence rather than just doing things for people. One member of staff said, "Often in the past people have not been allowed to develop, our culture is to promote independence and we often stand back and let people do things for themselves." And, "We get people ready for independence, we strive to give them choice, manage risks, like their finances and train people how to manage themselves." Developing people's skills increased their levels of independence.

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person. People told us about the things they liked to do, for example working with animals, and we could see this was supported by staff.

Staff we spoke with were friendly and happy to provide care. Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. We found that

people were supported by caring staff that were sensitive in manner and approach to their needs. Staff described how they delivered friendly compassionate care. They told us how they made sure that people were comfortable and relaxed in their presence. Staff described how they made sure people had all they needed.

Information about people was kept securely in the office and the access was restricted to senior staff. The registered manager ensured that confidential paperwork was regularly collected from people's homes and stored securely at the registered office. Staff understood their responsibility to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

One person said, "I can talk to staff and think they would listen."

People received personalised support which met their specific needs. A member of staff commented, "Since we have been a supported living service people have learnt to cook, shop and make more choices." People felt their needs were reviewed and kept up to date and this was confirmed in people's records and by staff.

People told us that they had a care plan folder in their home with information in it about their care. Records showed that people had been asked their views about their care. People told us they had been fully involved in the care planning process and in the reviews of those plans. Reviews of the care plan could be completed at any time if the person's needs changed. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff. We could see that care plan reviews had taken place as planned and that these had been recorded.

Person centred reviews took place with health action plans and communication passports in place. Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and their access to health services. Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. For example, if they were admitted to a hospital.

Staff told us they read people's daily reports for any changes that had been recorded and the registered manager reviewed people's care notes to ensure that people's needs were being met. When we spoke with staff they showed that they knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs.

Staff understood the recorded behavioural triggers for each person. The registered manager sought advice from health and social care professionals when people's needs changed. Records of multi-disciplinary team input had been documented in care plans. These gave guidance to staff in response to changes in people's health or treatment plans. Information was displayed for people to access about health services and advocacy support. This meant that there was continuity in the way people's health and wellbeing were managed.

People we spoke with felt at ease to raise concerns with staff or any member of the management team. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw from care plans that when people had met and chosen activities these had been organised by their key worker and they recorded when they had taken place. People had one to one meetings with staff. At these meetings people were encouraged to talk about any concerns or complaints they had about the service. Staff understood that people with learning disabilities may not always be able to verbally complain. Staff

compensated for this by being aware of any changes in people's mood, routines, behaviours or health.

The provider had a comprehensive complaints and compliments policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was displayed in pictorial formats. This assisted people to better understand the process. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. There had been two complaints received since the service was registered. These had been responded to and investigated within the provider's complaints policy. All people spoken with said they were happy to raise any concerns. The registered manager always tried to improve people's experiences of the service by asking for and responding to feedback. The meetings and communication in the service reduced the risk of situations requiring people to make complaints.

Good

Is the service well-led?

Our findings

People and staff told us the service was well led. One member of staff said, "We can speak up at meetings, we all bring ideas and the management take on board our suggestions for improvements." They went onto explain how they had suggested a new way of matching up each person's hours to their daily support records. This was now being tested in the service.

The service was well led by managers who maintained their skills and understanding in learning disability services. The registered manager and their staff team were well known by people. We observed staff being greeted with smiles by people. The registered manager had extensive experience of delivering person centred care to people with learning disabilities and complex needs. It was clear from our discussions with them that they had the skills and motivation to lead the staff team in the delivery of positive outcomes for people.

The values of the organisation were clearly noted and identified within organisational policies and provider statement of purpose. The providers vision was based on enabling people with disabilities to take control of their lives and be less isolated in their communities. The service aims were to be agile working with technology, work in partnership and with the community. Staff told us that they learnt about the values of the organisation from day one of their employment. Staff were committed and passionate about delivering high quality, person centred care to people living with learning disabilities and autism.

Learning and practice development were supported by the providers. The registered manager attended networking events such as the learning disability practice forums. Staff learnt about Positive Behaviour Support (PBS) and Person Centred Planning (PCP). PBS is recognised in the UK as one of the best way of supporting people who display, or are at risk of displaying, behaviour which challenges care services. Learning was disseminated to staff teams through training, supervision and monthly team meetings. This meant that staff were well informed and could respond to people's behavioural needs positively.

The provider's quality assurance systems were based on a person centred culture, putting people who lived in the service at the centre of everything they did. People's wider circles of support were included, such as staff, relatives and health and social care professionals. Staff demonstrated their commitment to a lifestyle approach model of care that fostered a proactive, positive value led approach to the management of challenging behaviours. For example, one person had been provided with a new home and bespoke staff team. People and staff were asked for feedback about the service by the provider through forums, monthly tenant meetings and questionnaires. Newsletters and a provider magazine was used to inform people of developments or responses to feedback. People's experiences from recent feedback were good.

People were protected by consistent and comprehensive quality audits. The provider employed a dedicated quality and compliance manager. They supported the registered manager to monitor quality and carry out audits of the service on a monthly and quarterly basis. Audits enabled them to identify areas of the service that needed improvement which they recorded and took the actions required. They completed audits of all aspects of the service, such as medicines, kitchen hygiene, infection control, care plans, staff training and

staff health and wellbeing. For example; There had been a recent improvement in the way the service supported relatives to manage people's medicines, which included training."

Actions taken as a result of analysis included changing behavioural management guidance for staff referring individuals to health care professionals, refresher or additional training for staff and sharing information with relatives, the local safeguarding team and CQC.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service. Staff had signed to say they understood the policies. Staff understanding of the policy's they should follow was checked by the manager at supervisions and during team meetings. The providers systems enabled senior managers and directors to have oversight and governance of health and safety audits and risks were monitored at corporate level. This meant that people and staff were protected by organisational oversight.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.