Joseph Rowntree Housing Trust

Independent Living Service - East Yorkshire

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

We undertook an announced comprehensive inspection on 31 March 2016. We gave the registered provider 48 hours' notice of our intention to undertake an inspection. This was because the organisation provides a domiciliary care service and we needed to be sure that someone would be at the agency office that could assist us with the inspection. This service was registered by the Care Quality Commission (CQC) on 30 July 2014 and this was the first inspection of this location. Independent Living Service - East Yorkshire is run by Joseph Rowntree Housing Trust. People hold their own tenancy agreements and there was a mix of individual and shared accommodation across the scheme. The service is registered to provide personal care for younger adults with a range of needs including, learning disabilities or autistic spectrum disorder and physical disability.

At the time of our inspection, 13 people received a personal care service. The service provides community based care and support services from the registered office location, in Market Weighton.

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

People who used the service told us they felt safe and we found that care workers had received training in safeguarding adults and knew how to protect people from abuse and avoidable harm. Risk management plans were in place and they were regularly reviewed and updated in line with the person's needs.

People's care files were person centred this meant they focused on the individual. Care plans included an easy read version (easy read refers to the presentation of text in an accessible, easy to understand format) and a section, 'What's Important to Me'. This recorded personal history, personal preferences, interests and aspirations of people. Care workers told us this documentation helped to provide people with holistic person centred care. The registered provider had a system in place to record, investigate and learn from Accidents and incidents. We saw that because of these investigations, the registered provider had implemented risk assessments and had updated peoples support plans.

The registered provider undertook a variety of recruitment checks to help ensure care workers recruited were considered suitable to work with vulnerable people. Once employed, care workers underwent a continuous induction and probationary period where they received appropriate training and competency checks to help meet people's needs and to check they upheld the basic values of care.

There were enough members of staff to meet people's needs. People and care workers raised concerns around the use of agency staff. The registered manager told us they had an action plan in place to recruit permanent care workers and appropriate checks were carried out when agency staff were used. The

registered provider recognised the importance of building relationships between people and the carers and told us they had involved people in the recruitment process. People were assigned a keyworker who acted as a first point of contact for all their needs and documented and updated their care plans and associated records in line with their needs, wishes and preferences.

The registered provider had a medication policy and procedure in place and this followed guidance provided by 'The National Institute for Health and Care Excellence' (NICE). We saw this was reviewed and updated at least annually. There was clear guidance for people who were prescribed 'as and when needed' (P.R.N) medication and appropriate guidance by way of pictorial body maps was documented for the application of patches, creams and emollients.

Care workers had received training and understood the requirements of The Mental Capacity Act 2005 (MCA). Where people's capacity was deemed in question, the provider liaised with appropriate health professionals in line with the MCA.

The registered provider had appropriate housekeeping, maintenance and inspection programmes in place for the environment, equipment and utilities. These were up to date and helped to ensure the safety of the premises from people, staff and others. We saw people were kept safe from the risk of emergencies in their home. People had a risk assessment in their care files for the environment and a personal emergency evacuation plan (PEEP).

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw peoples dietary requirements noted in their care plans that included details of food likes, including any religious dietary requirements and information on supporting people with good nutrition and hydration.

Care workers told us they felt well supported and understood their roles and responsibilities. They told us they had positive relationships with other health professionals to support people when the need arose.

We received positive feedback about the leadership and there was a high degree of confidence in how the service was run. Care workers we spoke with told us the registered manager was approachable open and honest. Management understood how to meet the conditions of their registration with the CQC.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and there were systems in place to help protect people against the risks of bullying, harassment and abuse.

Care workers had received training and guidance was followed to help manage people's medicines safely.

People and care workers raised concerns around the use of agency staff, but we saw sufficient numbers of care workers who had the skills and knowledge to support people were available.

Is the service effective?

Good

The service was effective.

People were supported by a keyworker and care workers had received appropriate training and competency checks to meet appropriate standards of care and people's needs.

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

People were supported with their dietary needs and helped to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

We observed that care workers cared about the people they supported and that they took time to get to know them.

People were involved in planning their care, and were provided with the information they needed in a format they could understand.

We observed people were treated with dignity and respect by care workers. Care workers understood how to maintain people's

confidentiality.

People's independence was encouraged and supported.

Is the service responsive?

Good

The service was responsive.

Care records were detailed and included a person centred information. Care workers followed this and other documentation to deliver individualised care and support which reflected people's personal preferences and lifestyle choices.

People knew how to complain. Compliments and complaints were encouraged and responded to with appropriate procedures in place.

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

Is the service well-led?

Good

The service was well-led.

The service was open and promoted a positive, person-centred culture.

People and staff felt supported by the registered manager. The registered provider and registered manager had implemented a number of quality assurance procedures to monitor the care provided.

There was a clear management structure in place and care workers understood their roles and responsibilities.

Independent Living Service - East Yorkshire

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 31 March 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the locations office when we visited. One adult social care inspector undertook the inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider. The registered provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spent time with four people receiving services in their own home. We interviewed three care workers and spoke with the registered manager. We looked at records relating to people's individual care; this included the care planning documentation for five people, four care worker's recruitment and training records, the care worker rotas, records of audits, policies and procedures and records of meetings and other documentation involved in the running of a domiciliary care agency.

Good

Is the service safe?

Our findings

People receiving a service told us they felt safe. We saw they were protected against the risk of potential abuse and bullying. One person told us, "I am very happy and feel safe living here." Care workers discussed with us what signs of abuse they looked out for and what they would do if they had any concerns about people's safety. One care worker said, "We undertake safeguarding training as part of the induction programme and have online refresher training every year," they continued, "We make sure people are kept safe, emotional abuse can be more difficult to identify, but we discuss any concerns with the manager." We saw care workers had undertaken appropriate safeguarding training and that this included whistleblowing. The registered provider had a comprehensive policy and procedure about safeguarding adults from abuse that was written in conjunction with the local authority procedures. We also saw that the registered manager worked closely with the safeguarding team, to ensure people were protected and that incidents were fully investigated.

People were kept safe as risks to them and others were assessed and managed by staff. We looked at people's care plans and saw that these provided up to date information about their care and support needs. We saw documented risk assessments and support plans were in place and that these were regularly reviewed. People's independence was supported and respected using risk assessments to identify and work within the capacity of the individual to undertake daily activities in a safe way. One person's file we looked at contained a mobility risk assessment. This had been reviewed with the person and included guidance for supporting the individual to mobilise in accordance with their needs and preferences.

Other people's care files included risk assessments for falls, infection control, and administering of medication. These were reviewed and updated with the involvement of people, families and professionals and along with associated support plans helped to keep people safe and promoted independent living.

The registered provider had a policy and procedure in place to manage and record accidents and incidents. These were logged monthly onto a quality assurance system where they were investigated and analysed by the health and safety officer. Because of these investigations, the registered provider had implemented risk assessments and had updated support plans. We saw evidence that risks were managed using input from other health professionals such as a physiotherapist and occupational therapist and that additional aids and adaptions were accessed to help prevent re-occurrence and to help keep people safe.

We looked at staffing and we saw from the staff rotas that the registered provider had sufficient care workers in place and that this included the use of agency staff. People told us that care and support was provided by regular care workers, but some people and care workers raised concerns regarding the use of agency staff. One care worker told us, "Use of agency staff can be a problem as it takes time for them to get to know people." Another care worker told us, "When we have a lot of sickness the manager brings staff across from our service in York," they continued, "It is improving and we are constantly trying to recruit new staff." We asked the registered manager about this and they told us they were aware of the concerns. They told us, "We have an action plan in place to reduce the use of agency, but where this is required, regular workers are requested." The registered provider had a folder that contained profile details of agency staff and this

included their name, date of birth, base, suitability checks, references and details of training they had completed. This helped to ensure people received regular care workers and that appropriate checks were in place to ensure their suitability.

The registered manager explained that all staff had thorough checks carried out before they could start working at the service. We looked at staff files and saw that the dates were recorded for when references and Disclosure and Barring Services (DBS) checks had been received. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The registered manager advised that care workers shadowed experienced workers before being allowed to work independently with people. It was clear that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

The registered provider had a medication policy and procedure in place and this followed guidance provided by 'The National Institute for Health and Care Excellence' (NICE). We saw this was reviewed and updated at least annually. We saw changes were communicated and discussed with care workers at staff meetings and that they were required to sign to say they understood any changes. Care workers told us additional training was provided when appropriate. We looked at care workers files and saw that care workers involved with administering medication received appropriate training and the registered provider undertook competency assessments on care workers to ensure the training had equipped them with the skills needed to safely administer medication.

People's care files contained risk assessments to assess what level of support they required with their medicines. Where people needed support, we saw that support plans included information about the type and frequency of medication and that this reviewed in line with any changes. Medication was kept in locked cabinets in people's accommodation. We looked at Medication Administration Records (MAR), we saw that these were completed appropriately and evidenced when medication had been administered.

The registered manager showed us guidance they used to help them provide a framework for decision making about consequences for care workers who made medication errors. We saw care workers errors with medication were scored against the possible impact on the health and well-being of the person. Once three or more points were achieved, care workers undertook supervision with an assessor and additional training was undertaken. The care worker was not allowed to administer medication until deemed competent and had received additional observational spot checks. This process helped to ensure people received their medication in a safe and controlled way by competent care workers.

There was clear guidance for people who were prescribed 'as and when needed' (P.R.N) medication and appropriate guidance, by way of pictorial body maps, were completed for the application of patches and creams. This ensured care workers had up to date information to administer all types of medication correctly.

People had a risk assessment in their care files for the environment. These included personal emergency evacuation plans (PEEPs). PEEPs are documents, which advise of the support people need to leave their home in a safe way in the event of an evacuation taking place. We saw these included information in an easy read format and advised people what to do, what equipment may be required and included an assessment of need in the event of an emergency.

The registered provider undertook regular checks of the environment to identify and manage risks in

people's homes. We saw fire safety risk assessments were in place and up to date. These included the weekly recording of fire alarm tests and checks on emergency lighting and fire extinguishers in people's homes. Care workers told us and we saw from their files that they had received up to date training in fire safety at work and fire safety awareness training by the chief fire officer from Humberside fire and rescue service.

The registered provider had policies and procedures in place and we saw that care workers had received training in health and safety awareness, infection control and food safety. We observed care workers using personal protective equipment (PPE) such as aprons and gloves during our inspection. An infection control audit had been carried out in January 2016 and included details of monthly water temperature checks on people's homes and staff facilities. Health and safety checks were documented and maintenance and service contracts were in place and up to date on equipment for moving and handling of people and specialist baths. We saw details of premises checks including gas certificates, portable appliance testing, heating, and Tunstall cable services were completed and were all up to date. This meant appropriate measures were in place that helped to mitigate risks and helped to keep people safe.

Minutes of a staff meeting in January 2016 highlighted the risk from ice and darkness to staff in the office car park. The minutes documented that ice grips and head torches had been purchased to facilitate the gritting of the area to help keep people safe when arriving and leaving the office. The registered provider had a maintenance log book with a maintenance programme in place and had the use of an internal maintenance team. Jobs were recorded by date, details, signed and completed and we saw these were all up to date and helped to ensure that the registered provider had taken steps to ensure that premises and equipment were managed to keep people safe.

Good

Is the service effective?

Our findings

People told us that care workers had the required skills and knowledge to meet and understand their needs. Care workers told us there was an allocation process in place that ensured a person who received a service was allocated a dedicated member of staff. These staff were known as keyworkers and they were responsible for liaising with the person and discussing and documenting their changing needs. Keyworkers updated people's care plans and understood the person's needs and we saw that this included key areas of care such as medication and help with activities such as shopping and visiting the doctors. People told us they were involved with the staff recruitment process including their keyworker and that this helped to ensure care workers were a suitable match for people and understood their needs.

The care workers we spoke with told us that they received an induction to the service when they began working for the organisation. They told us that they attended a corporate induction over the first week before shadowing existing care workers and progressing to working on their own with people. One care worker told us, "The induction was very extensive as it provided me with the information and skills I needed to start work." Another care worker told us, "My employment started a long time ago, I know the induction has improved and there is plenty of other training available as we need it."

All new care workers were enrolled on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. It assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. We saw care workers undertook a structured probationary period after completing their induction. This included a documented progress review where any outstanding objectives were recorded and achievement dates scheduled. We saw care workers had access to an electronic database of learning via a unique access code that recorded their activity and outcomes. This system enabled the registered provider to ensure care workers had undertaken all mandatory training and that refresher training was scheduled and undertaken.

We looked at training records for four care workers. Training was a mixture of online and e-learning and included equality and diversity, first aid, safeguarding, manual handling, medication, fire safety, food hygiene, health and safety, dementia awareness, person centred approaches, nutrition and hydration, infection control, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw person specific training was available to care workers as required in order to help meet people's individual needs.

Care workers had their competency checked after undertaking training. We saw moving and handling people training was followed up with practical skills assessments and this was recorded. Where competencies had not been achieved, additional training was provided. This meant that care worker's knowledge and skills were kept up to date and that care workers were competent in delivering care and support to people.

We saw that the registered provider undertook quarterly one to one and observed supervisions with care workers and we saw these resulted in an annual review that included support with personal development. One care worker said, "We have some good supervisions with the manager where we have the opportunity

to give feedback and discuss any concerns on our performance and ensure we are following best practice." This meant care workers received effective support, induction, supervision, appraisal and training to support and care for people. The registered provider told us on the Provider Information Return (PIR), "During the six month probationary period, targets are set for new staff; a documented meeting takes places with staff at the 3 and 5 monthly points within the probationary period and bi-monthly supervision/appraisal of staff follows."

Care workers had received training and understood the requirements of The Mental Capacity Act 2005. 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Care worker's we spoke with said, "We always try and provide opportunities for and encourage people to make their own decisions" and "We always assume people have the capacity to make decisions and we encourage them to do so."

We spoke with the registered manager who told us people's risk assessments and care plans were continually reviewed and updated as people's needs changed and we saw people signed their agreement to their care records. They told us and we saw where they had concerns that people's needs had changed and this had resulted in a reduced capacity to make particular decisions they had commenced applications for further assessments from the local authority in line with the MCA.

We asked management and care workers how they supported people who may become anxious or distressed. The registered manager told us "We avoid restraint and use de-escalation techniques in line with policy and procedure." A care worker told us, "We don't restrain people, we record their responses to our support and care to identify any trends and we work with other health professionals to try and reduce any negative behaviour." We saw where required, that care workers received training in managing people that displayed anxious behaviour.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw people's dietary requirements noted in their care plans, which included details of food likes, any religious dietary requirements and information on supporting people with good nutrition and hydration. The support people received varied and was dependent on their individual circumstances. One person told us, "I don't have any dietary requirements, staff take me shopping and I even have Pizza once a week." Another said, "I can eat what I want, staff help me prepare it and they go to the supermarket with me, but I can choose." We spoke with care workers and asked them how they supported people to eat healthily and how they recognised people's individual needs. One care worker told us, "We talk with people and discuss their preferences which we then note in their care plans." Another said, "If people have dietary needs, they are documented in their care plan," they continued, "If I had concerns about a person's health I would discuss it with the senior, we would document the concerns and monitor the person daily. We may involve a GP or we might refer them to a dietician." This helped to ensure that people gained sufficient support with eating and drinking to maintain a balanced diet.

Where people's needs changed quickly, we saw the registered provider had made referrals to a range of health professionals including opticians, doctors, occupational health staff and physiotherapists. We saw care plans contained a record of medical appointments and an individualised 'Health Action Plan' that identified a person's daily care needs. These included general health, exercise, weight and skin integrity plans. We saw these were reviewed at least monthly and as appropriate involved documented, multi-

disciplined, team visits to help support and care for people. This meant care workers understood people's needs and the registered provider had ensured processes were in place and information was available to ensure people's day-to-day health needs were met.

We were shown around people's accommodation with their permission. People told us they had been involved with the decoration choices in their bedrooms. Bedrooms were designed to allow people to navigate with their personal equipment. Double doors provided people with access to outdoor spaces and the car park where there was adequate space for people to manoeuvre and access their vehicles. The design of the accommodation encouraged and promoted people's independence ensuring their mobility was provided for.

Good

Is the service caring?

Our findings

It was clear form our observations during the inspection that care workers knew the people they cared for and that people knew their care workers. We saw care workers communicated with people in the way they wanted to which was clear and understood by people. A care worker told us, "Care staff are all caring, we treat people like family" and "It is such a nice place to work." We asked another care worker how they had got to know people's likes, dislikes and their preferences. They said, "We ask them, we spend time with people and get to know them, information is documented in their care plans, and if we find these change, we update their care plans."

Care workers told us they completed an induction period when they shadowed existing staff and were introduced to people. The registered manager told us, "We ask people and care workers what they think of each other to try and improve compatibility, if there are any problems or concerns we can move staff around, we try and keep everybody happy." People told us they were happy with their care and we saw that they knew their keyworker. A person told us, "[Name] is really nice, they care about me."

The registered provider told us on the PIR, "When we are planning to provide a service for an individual we work with the resident, their family and other health and care professionals to fully understand their care and support needs which informs the 'What's Important to Me' documentation." We saw from care files that there was good documented communication between the registered provider, people, their families and other health professionals. People told us their views were listened to and that they were involved with developing their own care plan and that it met with their needs. One person receiving a service told us, "I am listened to and I have my views included in my care plan." They continued, "Staff are good at listening to what I want."

Discussions with care workers revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. People we spoke with told us there were no restrictions on visitors to the service. One person told us, "My mum visits whenever she wants to and I can speak to her using my telephone."

The registered manager told us that where people did not have full capacity or were unable to express their views, they were provided with information and assisted to make a referral to an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

Care workers received training in privacy, dignity and confidentiality during their induction and people told us they were treated with dignity and respect. A care worker told us, "We treat people as we would wish to be treated in our own home; that means providing towels and dressing gowns for people, closing curtains and respecting their wishes." Care workers discussed with us how they communicated with people to ensure people understood the care they received and that they agreed with it. We observed care workers knocked

and waited for permission before entering people's homes in recognition of their preferences.

The registered provider told us on the PIR, "We regularly reinforce the behaviour standards we expect in team meetings and supervisions and take seriously any reports of behaviour which does not reach our expectations." We saw that the registered provider undertook documented observations on care workers whilst they delivered care and support to people to ensure they upheld the basic values of care. Care workers discussed with us how they maintained people's confidentiality. One care worker said, "Nobody has a right to know something they don't need to know," they continued, "We only disclose information with a person's agreement and only when someone else needs to know such as for safeguarding people."

We spoke with the registered manager about how they supported people to make their preferences and wishes for end of life care known. The registered manager told us they were reviewing the process and were updating care and support files to include people's preferences and to ensure choices for their end of life care were clearly recorded, communicated, kept under review and acted on. They told us, 'The palliative care team support staff, residents and families when a terminal diagnosis has been made.' Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses.

The registered provider showed us a Dementia Information box. This provided information and resources for use by people their families and staff to help them understand, support and care for people with dementia. The box included posters, films documenting people living with dementia, their stories and diaries. Staff confirmed and we saw they had undertaken dementia friendly training and understood how to support and care for people with dementia and their families.

Good

Is the service responsive?

Our findings

People told us that they were involved in discussions regarding their care. People confirmed that the care delivered was responsive to their changing needs. We looked at people's care files, we saw they were thorough and focused on the person. Care plans included an easy read version and a section entitled, "What's Important to Me." This had been completed with people using the service and recorded information about their personal history, personal preferences, interests and aspirations. Care workers told us they used this as a point of reference, which helped them to deliver personalised care and support for all areas of a person's life. We saw people's care files contained a planned weekly timetable. This provided an overview of the person's needs and preferences for the week ahead and included personalised care such as one to one sessions and shopping activities. Care files contained an easy read formatted care and support overview. These had been completed with input from people and as appropriate their families and other health professionals. The overview provided a quick reference to people's choices and preferences, which included their morning routine, personal care, communication, finances, health/ medical conditions, medication, mental health/behaviour, mobility and movement, nutrition, relationships, daily living and work/leisure time care and support.

We saw one person had documented activities that included "I like to go to the day centre four days a week and I like to walk in the town, visit the shops and go to the duck pond." We observed staff taking people into the town and people told us they were assisted to visit the shops. One care worker told us, "We always ensure that care needs are provided for, but we can't always support people with none care needs at the time they request it," they said, "It's all about having staff available so people may have to wait sometimes." Another care worker told us, "We could always spend more time with people, but the service is all about promoting independent living, I think we do that quite well." People we spoke with told us, "As long as it's safe we can do anything" and "I do seem to have the opportunity to do what I want to do."

The registered manager told us, "At times such as the annual review of care for people, we engage with the local authority, other health professionals and we invite family members to ensure we have a holistic care plan in place to meet a person's full needs."

People were encouraged to submit feedback, share their experiences or raise any concerns. People we spoke with understood how to raise complaints. One person told us, "If I have any concerns I speak with staff or the manager." They told us, "The service is responsive and someone always deals with any issues I may have." The registered provider had a complaints procedure in place and care workers we spoke with were clear of the importance of reporting and recording any complaints. The registered manager told us details of complaints and a summary of the action was collated centrally and discussed by senior management. We saw feedback was then discussed at weekly management meetings and lessons learnt were fed back and discussed at weekly staff meetings. This feedback provided a learning opportunity and helped to improve the delivery of care and support to people.

The registered manager showed us the results of an annual survey sent out to people receiving services. We saw thirteen out of fifteen people receiving a service had participated. Responses showed 100% agreed that

care treatment and support was available when needed. 54% of respondents thought they had a real say regarding how care workers provided care and support and 46% neither agreed nor disagreed. Comments included "Some staff treat me as an individual, but not all" and "I can't contribute to the service due to a lack of understanding." We spoke with the registered manager about the feedback and comments raised, they told us the survey had just been completed and they were in the process of evaluating and responding to the findings.

The registered provider worked with other partner agencies including health and social care professionals who were involved in people's care. This helped to ensure that people received consistent co-ordinated care.

Good

Is the service well-led?

Our findings

At the time of our inspection, there was a registered manager in place. The registered manger and a deputy supported us at our inspection. We received positive feedback about the leadership and there was a high degree of confidence in how the service was run. Care workers we spoke with told us the registered manager was approachable open and honest. People knew the manager by name, one person told us, "If I had a complaint I would speak with [manager's name], they are quite approachable." There was a clear management structure in place and care workers had an understanding of their roles and responsibilities.

We discussed the submission of notifications by the registered manager as part of their registration requirements with the Care Quality Commission (CQC) and it was clear they understood their responsibilities. Our records showed that notifications were appropriately submitted in a timely manner. This meant they were following conditions of their registration.

Care workers told us the service had a positive open culture. A care worker told us, "It's a very good organisation to work for." Another care worker said, "Everything is very organised with an expectation that we deliver a high standard of care and support to people" they continued "Joseph Rowntree Trust is set up to encourage us [care workers] to progress as individuals, it's a very supportive organisation." The registered manager told us they had a staff incentive reward scheme. The scheme recognised when care workers had worked well or gone beyond what was expected of them with a monetary award scheme voucher.

We saw that peoples care was person centred and empowered people to make choices and remain independent in a safe, managed way. Care workers told us they were supported and kept up to date with changes, not just for people, but also in best practice and organisational changes. A care worker told us, "We are constantly updated about people's needs, not just verbally and at staff meetings but information is also documented in daily hand over notes and from new information in people's files."

A person receiving a service told us the registered provider held regular six monthly resident meetings where residents were able to express their views and air any concerns. The registered manager told us that any outcomes from reviews or residents meetings were usually dealt with through review and inclusion in support plans.

The registered provider had a statement of purpose. We saw that this promoted the organisation's aims and objectives with an emphasis on promoting people's independence, involvement, choice and their right to be treated with respect and included visions and values of the service. We saw that there was a continuous programme of quality assurance, which upheld those values. Monthly audits were undertaken followed by a quarterly evaluation of the service. We saw this resulted in action plans being implemented for improvement where targets were not met. We asked care workers if quality assurance helped to drive improvement. One care worker told us a recent service user survey had asked "Are you listened to?" and a response was returned from a person receiving a service requesting assistance with the cleaning of their cars. The care worker told us because of the feedback the registered provider was looking into employing a valet to help with this task. This meant people's views, not only on the care and support they received, were listened to

and acted on. A care worker told us, "We always try and meet people's needs, whatever they are."

Care workers and people using the service told us and we saw from care plans that the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people. The registered provider worked with a range of services and health professionals including the local authority, local GP practice, district nurses, CPN's, consultant psychiatrist and speech and language therapist. This helped to ensure a multi-disciplinary agency approach was used to meet peoples care and support needs.

The registered manager told us they attended monthly registered managers meetings with senior managers and organisational managers from other registered services. The registered provider told us on the PIR, 'The registered manager also attends a professional development and action learning network which specifically focusses on the management of adult social care services.' 'Managers and Coordinators are taking part in the 'Joseph Rowntree Housing Trust Leadership and Development Programme' and benefit from bringing all Joseph Rowntree Housing Trust registered managers together, with senior management team, on a monthly basis.' The registered manager told us the programme helped them to measure and review the delivery of care, treatment and support against current guidance.