Clearwater Care (Hackney) Limited

Clearwater Care

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 30 May 2017 with follow up visits on 31 May and 1 June 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the registered manager would be available for the inspection. This was the services first inspection since being registered with the Care Quality Commission.

The service provides 24 hour care and support to fifteen people with learning disabilities who live in their own homes across six different locations.

The service has a registered manager in post. 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.

The service was managed by the registered manager and two service managers who shared responsibility for running the service on a day to day basis across the six locations.

People told us they were happy and felt safe using the service. We saw that people were comfortable and relaxed with staff. Relatives told us their family members were safe. Staff had received training in safeguarding and knew how to protect people from the risk of abuse and how to report any concerns.

Risks to people's safety were assessed and guidance was provided to staff on how to manage them. Staff were aware of the risks to people and the management plans in place keep people safe from harm. There were sufficient staff deployed who had been safely recruited to meet people's needs.

Medicines were managed safely and people received their medicines as prescribed. People received appropriate support to take their medicines by staff who were trained and assessed as competent to administer medicines safely.

Staff received an induction, mandatory and specialist training so they had the skills and knowledge to meet people's needs. Staff felt they were well supported by the management team and received supervision and annual appraisals to help them develop professionally.

The service supported people to have enough to eat and drink which reflected their preferences and helped them maintain a healthy balanced diet. People's health and wellbeing was maintained. The service kept detailed health records and shared this information appropriately with the relevant health and social care professionals to ensure that people received any treatment they required in a timely fashion.

Care was planned and delivered in a way that met people's needs and took account of their wishes and preferences. Staff encouraged and supported people to maintain their independence and confidence.

People were involved in the assessment of their needs and their consent was sought before providing care and support.

Staff were caring and treated people with kindness, dignity and respect. People and staff had positive relationships. Staff knew people well and understood people's needs and the way they communicated and used this knowledge and understanding to help people make decisions.

People received care and support in a personalised way and were supported to make choices about how they wanted to live their day to day lives including exploring interests and maintaining relationships that were important to them. Staff supported people to take part and try new activities and experiences in their homes and in the community.

The provider had a complaints policy and procedure in place which was shared with people and their relatives who told us they knew how to raise concerns or complaints.

The culture within the service was person-centred, open and transparent with a focus on empowering people and promoting independence.

There was a clear management structure in place and staff and people felt comfortable talking to the managers about any issues and were sure that any concerns would be addressed.

We have made a recommendation about reviewing the current system of sharing information with people's relatives and/or representatives.

There were systems in place to monitor the safety and quality of the service provided. People's views and opinions were sought through ongoing reviews and satisfaction surveys. Suggestions for change were listened to and actions taken where possible to improve the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from the risk of abuse by staff who understood their safeguarding responsibilities. Risks to people were well managed. People received support to take their medicines safely. The service employed sufficient staff who had been recruited safely to meet people's needs.

Is the service effective?

Good

The service was effective. Staff received good quality training and felt well supported through supervision, observations and appraisals to develop professionally and be competent in their role. People were supported to make decisions and give their consent to care and support. The service supported people to maintain their health and wellbeing and had support to access to health and social care services.

Is the service caring?

Good

The service was caring. Staff were kind and patient and had formed positive relationships with people. People were treated with dignity and respect and staff listened to them and involved them in discussions around their care and support. Transitions were managed very well which minimised any anxiety and distress people experienced in new situations.

Is the service responsive?

Good

The service was responsive. People received personalised care and support from staff who knew them well and respected their preferences. People led full lives as were supported to engage in a wide range of activities at home and in the community. There were systems in place to respond appropriately to concerns and complaints.

Is the service well-led?

Good

The service was well-led. There was an established registered manager in post who provided clear leadership and direction of the service. We recommended that the service review its methods of information sharing with people's representatives to foster good communication practices. The culture within the

service was one of person-centredness, transparency and a willingness to learn. There were robust quality assurance mechanisms in place to monitor the quality and safety of the service and drive improvements.

Clearwater Care

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 was 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 30 May 2017 with follow up visits to people in their own homes on 31 May and 1 June 2017. The inspection was conducted by two inspectors and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service for younger adults who are often out during the day; we needed to be sure that someone would be in.

Before the inspection registered manager had completed 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 the PIR and at all the information we had collected about the service. This included information received and notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law. We also reviewed information from commissioners and stakeholders who worked with the provider.

During our inspection visit, we spoke with three people who received care and support in their own homes. We also spent time observing the interactions between the people and staff. As part of the inspection process we spoke to the registered manager and four members of staff. We also spoke with or received written feedback from five relatives of people who used the service. We also received written feedback from two health and social care professionals who were familiar with the service.

We reviewed five people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how information was gathered to improve the service. This included medicine records, the provider's quality assurance audits, satisfaction surveys and records of complaints, accidents and incidents. We also looked at four staff files including recruitment and supervision records.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe with the staff supporting them. One person told us, "I'm safe, this is my home." Relatives told us they felt the service was looking after people well and keeping them safe. One relative said, "I have peace of mind, knowing [person] is safe." Another said, "If [person] wasn't happy there, they wouldn't go back." We saw that all of the people we met looked relaxed and happy with the staff who supported them.

The service protected people from the risk of abuse through appropriate safeguarding policies and procedures and staff training. Safeguarding people from abuse was discussed regularly with staff during team meetings and during supervisions to reinforce learning and promote awareness. Staff knew about the different forms of abuse and how to recognise the signs that someone was being abused. For example, one staff member told us, "I would notice if a person was quieter or if they become isolated or their mood changed around people." Another said, "I would look for bruises, or if someone was withdrawn or their personality changed."

We asked staff what the procedure was for reporting concerns what they would do if they thought someone was being abused. One staff member told us, "I would report this straight away; we have a 24 hour on call and a manager for safeguarding." Staff understood the importance of contacting external agencies to escalate their concerns if necessary. A staff member told us, "I would go straight to CQC."

Staff were aware of the provider's whistleblowing policy and procedure and told us they had no concerns about any of their colleagues' practices but they would not hesitate to report something if they had any worries. Staff were confident that the management team would deal with any concerns to ensure people were protected.

There were systems in place to protect people from the risk of financial abuse. People's money was kept securely locked and stored in individual wallets. Records were kept of peoples monies coming in and going out and this was checked by staff at each change of shift or when a person wanted to take some money out. We looked at the written records and saw that the amounts totalled matched what people had in their wallets.

The registered manager had raised safeguarding alerts with the local authority or police in a timely manner when incidents occurred that put people at risk. They kept a register of all open safeguarding alerts raised to monitor their progress and ensure that they were dealt with appropriately and people received the help and support they required to keep them safe. We found that they thoroughly investigated safeguarding's in an open and transparent way, involving and consulting people's family as appropriate. A relative told us, "I attended a series of meetings concerning a safe- guarding incident. I was able to comment and raise any suggestions concerning the incident." We saw that the registered manager responded swiftly to changes in people's needs by putting appropriate strategies in place to minimise future risks to people.

There were systems in place to record, monitor and learn from accidents and incidents including

safeguarding alerts to improve the safety of the service. Incidents were reviewed and analysed at management level and also shared with staff to promote learning and improve practice.

The risk of abuse to people was reduced because the provider had effective recruitment and selection processes for new staff. Checks on the recruitment files for four members of staff showed that they had completed an application form, provided a full employment history and photographic proof of identity. The provider had also obtained satisfactory references and had undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use health and social care services. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

There were sufficient numbers of staff deployed to meet people's needs and to keep them safe. The staffing support required was agreed with the relevant funding authority to meet each person's individual needs. This ranged from 24 hour one to one staff support for people with complex needs to just a few hours support each day for people who were relatively independent. Staff told us the staffing levels were sufficient to meet the needs and preferences of the people they supported.
The provider operated a 24 hour on-call system for staff to access if they needed management advice or additional staff support. A staff member said "The manager tells us to ring them anytime if there is a problem or we need advice."

People had care plans which contained individualised risk assessments that were relevant to each person. The risk assessments included guidance for staff on how to manage the risks to ensure people received safe personal care and support. For example, there were risk assessments and control measures in place for managing behaviours, health conditions, finances & accessing the community. Risk assessments and management plans were proportionate and promoted people's rights and freedom. A person told us, "I come and go as I please."

Staff we spoke with had a very good awareness of the risks to people and how to minimise them. For example, one staff member told us, "We help [person] with food prep as they have no sense of heat." Another said, "Before you take [person] out it's important to check their risk assessment so you know that they can't go by bus."

Staff had received 'Maybo' training which provides support workers with strategies for preventing and defusing conflict and behaviours that challenge. All incidents of challenging behaviour were recorded, shared and analysed and action plans put in place to minimise the risk of recurrence. For example, where there had been conflict between two people whilst in close quarters together in the kitchen, a plan had been put in place that in the future staff would ensure that they used the kitchen separately.

Care plans included personal emergency evacuation plans for people in case of fire or other emergency situations. Staff were able to describe to us the evacuation procedures in the event of an evacuation being required. Although the service was not directly responsible for people's premises and equipment, the service still carried out checks to ensure the physical environment was safe. If any concerns were identified, the service informed the relevant landlord or housing association for action.

People required assistance to take their prescribed medicines and systems were in place to ensure people received their medicines safely. We saw that medicines were stored, recorded and administered correctly. Medicine administration records (MAR) showed that people received their medicines as prescribed. Staff

who administered medicines had been provided with training and had their competence checked by the registered manager to ensure people received their medicines safely.

The service managers carried out monthly audits to check the accuracy of medicine records and supplies. We saw that where medicine errors had occurred, appropriate action had been taken, for example, staff retrained and additional observations to monitor staff competency were completed.

Good

Is the service effective?

Our findings

People and relatives told us that the service was effective at meeting their needs. One person told us, "They are good at helping me, they help me with my medicine and taking me shopping, I'm getting a voluntary job and they are helping me with this." A relative told us, "The staff have a difficult job and they perform it well."

When new staff joined the service they received a comprehensive induction which provided essential training, based on the care certificate. The care certificate is considered best practice and represents a set of minimum standards that social care and health workers should stick to in their daily working life. Staff confirmed they had completed an induction when they started work at the service. They told us that it included completing a mandatory training programme as well as working alongside, and shadowing more experienced members of staff. This allowed them to get to know people before working with them independently. New members of staff were also given the opportunity to read people's care plans so that they could find out about them and how they liked their care and support delivered. The staff we spoke with were very knowledgeable about people's individual needs and preferences and we saw that they provided support in line with peoples agreed care plans.

The registered manager kept a record of staff training to ensure that staffs knowledge and skills were up to date. Where staff had particular learning needs, the service provided assistance through an allocated member of staff who was available to provide any additional learning support, for example, support for staff whose first language was not English. Staff told us the training they received was of a good quality and the provider also supported them with continuing professional development such as taking vocational qualifications in health and social care. This meant that staff had opportunities to develop their knowledge and skills so that they were competent in their role.

Staff told us they received supervision and annual appraisals. Written records showed us that supervision had been patchy in the last year due to staff changes and the transition to having service managers. However, things had now stabilised and the consistency of supervision had improved. One staff member told us, "I have supervision every month and an annual appraisal." Staff also told us that the service manager visited them every day and phoned them every morning to check that everything was ok and to ask what activities had been planned for people for that day. Staff training and development needs were discussed during supervision sessions which staff told us they found helpful and supportive. One staff member said, "Supervision, it's not to ridicule you or tell you off, it's to find out your strengths and any weaknesses and how they can help you and improve upon it; if you need more support, the manager can help you out."

Aside from mandatory training which included aspects such as safeguarding, infection control and medicine management, staff also received specialist training that was relevant and met the specific needs of people who used the service, for example, autism awareness. This meant that people were supported by staff who understood the difficulties they might experience and how best to support them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Staff told us they had received training in the MCA and were knowledgeable about their responsibilities in relation to the Mental Capacity Act 2005. For example, one staff member told us, "We let people make their own decisions whenever possible even if they are not always what we might think are sensible; we will try to prompt and encourage." Staff told us how they used different communication methods to support people with decision making who were non-verbal, for instance, through the use of pictures or showing people items for them to point at to make their own choices.

During our inspection, we saw that people were asked to give consent for their care and support. One staff member told us, "We always ask people and we discuss things like activity plans and Menu's together; I use pictures for [person] so they can make choices day to day." When shown around a house we saw that the staff member asked permission from the three people before entering their rooms. One person said they did not want us to enter and this was respected. There were two people who were out so staff member told us we could not go into their rooms without their permission.

When people lacked the mental capacity to make certain decisions the service followed a best interest decision making process and consulted the relevant people such as relatives or other health and social care professionals. A relative told us, "They [the service] include us in any important decisions that need to be made." Another relative said, "[person] needs support to consent; the family are consulted or advised of any decisions that need to be made concerning his care."

People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The Deprivation of Liberty Safeguards (DoLS) authorisation procedure does not apply to supported living services. For this type of service, where a person's freedom of movement is restricted in a way that may amount to deprivation of their liberty it has to be authorised by the Court of Protection. We saw that the registered manager had identified where authorisations may be required and had worked with the relevant authorities to ensure that people were not being deprived of their liberty unlawfully.

The service also considered any restrictive practices with a view to reducing the impact of any restrictions on people's freedom and choices. For example, where a lock was required on the kitchen door to minimise the risk of injury to a person, this was only placed on the door at night when the risk was greatest. It was then removed during the day giving the person unrestricted access under the supervision of staff to protect their rights whilst at the same time ensuring their safety.

We saw that many of the people who used the service had complex needs and demonstrated behaviours that could be perceived as challenging. Staff had received training in conflict resolution and all of the staff we spoke with demonstrated a very good awareness of the triggers that could potentially cause challenging behaviour and the actions required to diffuse situations. For instance, one member of staff told us, "With [Person] we look at their face and body language, their ears change to darker red, this is a sign they are becoming upset, at that point we change the environment."

When required, staff assisted or prompted people to have sufficient to eat and drink and to have a balanced diet. Some people were relatively independent and bought their own food shopping but some were assisted by staff to prepare their shopping lists and cook their meals. People told us they could have what they wanted to eat and staff would help them cook meals of their choosing. Some people had a weekly menu that was planned with a staff member at the beginning of week. A staff member told us, "They [people] plan

their menus but obviously if they change their mind they just pick what they want on the day." We saw that some people liked to choose their menu daily and their preferences were respected. Each person had an allocated cupboard and fridge space for their own food. Pictorial food choices were on display and in people's care folders if required to support their understanding and help them make food choices.

We saw that the service promoted healthy eating and encouraged and educated people to make healthy food choices to support their health and wellbeing. One person told us, "I cook my food from scratch and I grill it to be healthy." Some people enjoyed meals that reflected their ethnicity and culture and these food preferences were identified in people's care plans and staff supported people to prepare these meals in the way they liked.

People's health and wellbeing was monitored to help ensure they maintained good health. Care plans contained details of people's health conditions and any management plans in place. Staff prompted and supported people to attend their health appointments. All appointments were recorded in people's care records and included details of the reason for the visit, the outcome of the appointment and any treatment required. We saw that people were supported to see various health and social care professionals including: GPs, social workers, speech and language therapist, dentists and dieticians. A relative told us, "The staff act speedily enough when health concerns arise."

Good

Is the service caring?

Our findings

People and relatives said the staff were kind and caring. A person said, "The staff are really nice here." A relative told us, "They [staff] are very kind and considerate." Another relative said, "They [staff] treat [person] with respect and kindness; they have great patience and deal with their challenging behaviour with courage."

We saw that people had positive relationships with staff and observed that people were relaxed in their company. People and staff laughed and joked together and chatted as friends. Staff spoke to us about the people they supported with warmth and affection. For instance, one staff member told us, "I'm keyworker for [person] they are fantastic, I just love them."

People were encouraged and supported to express their views and staff listened to them. Staff had received training in Makaton which is a simple method of communicating through signs. They used this to communicate with people who were familiar with this system of signing. One staff member told us how a person had taught them their own unique signs and they then demonstrated these to new staff so that all staff could communicate effectively with the person. Where people required the support of an advocate to represent their views and wishes we saw that this had been organised by the service.

People had communication books which provided staff with detailed guidance on how to communicate with people through verbal and non-verbal means. This helped staff to involve people in decisions about their care and support people to feel listened to. We looked at the communication book for one person who could not verbally communicate and saw that it detailed the persons various moods and how staff could recognise and understand how they were feeling. For example, if the person was angry they would sit on the sofa with their hands clasped. Guidance included instructions for staff on the best ways to respond to each situation. Staff we spoke with demonstrated an excellent knowledge of the different methods of communication and the clues to look for to read people's moods and feelings. One staff member told us, "I look at [persons] ears, if they go a darker shade of red I know this is a sign that they are becoming upset."

People were treated with dignity and respect as staff spoke to and communicated with them with kindness and at a pace, which was appropriate to their level and needs. Staff gave people time to process what was being discussed and gave them time to respond appropriately to ensure people were engaged.

Independence was supported and encouraged. One staff member told us, "We try to encourage people to as much as they can; we assess day to day and get people involved, including housework." Another staff member said, "[Person] likes to do things by themselves, they just need prompting." Relatives told us that their family member's abilities had improved since they started using the service. For example, one relative told us, "[Person] does chores now, it's something they have worked on, they are doing the best they can do and staff are helping with this." People were enabled to move about freely and were not restricted by the staff member who supported them. On the day of inspection we saw that a person had just returned from a walk alone, a staff member told us, "[Person] likes to go for a walk daily."

Staff were knowledgeable about the people they cared for, their needs and what they liked to do. For example, one staff member told us, "[person] doesn't like noise places or crowds, doesn't like buses so we take cabs; they like music and the gym, they don't like to eat in public places, I shave them every Friday as this is what they like." Relatives we spoke to confirmed that staff knew people well. One relative told us, "Staff understand [person's] needs, I haven't any cause for concern about how they interact with him; they seem to understand him, they know what he likes and dislikes, I think that they know him really well."

Relatives and professionals told us that transitions of people moving into the service were managed exceptionally well. One relative told us, "The best thing about the service is how the transition was handled; they took their time about it; [person] gelled with the staff from the beginning; this is the first time [person] has moved and we have not had an uproar; no crying or sadness about wanting to go back to the old place." A social care professional we spoke with told us about the transition of a person they had been involved in. They said, "The transition was very well managed by the staff. They were professional in their management of the transition process and put together a plan. The transition was smooth and this is was mainly due to excellent communication with the family who are very important to this person."

People were enabled to maintain relationships that were important to them. People were supported to have contact with family members either at the home, off site or via telephone. One person was independent and visited family whenever they liked, another person visited their family member weekly.

Good

Is the service responsive?

Our findings

The service involved people and their relatives, if appropriate, as much as possible in the planning of their care through the assessment and support planning process. A relative told us, "We had an initial meeting with the management team and the social services team. We expressed our wishes for [person's] care package to be taken into account i.e. safety and the compatibility of the other service users etcetera." Following on from the initial assessment the service planned to complete annual reviews of people's care and support. However, the registered manager told us that they were behind in completing some reviews due to staff changes and changes to the review process within some local authorities. Consequently, there were mixed views expressed by relatives regarding the regularity of reviews. Three of the relatives we spoke with confirmed they had been invited to annual reviews. One told us, "I attend [persons] review meetings, together with other members of the family." However another relative told us, "We have to chase Clearwater for annual reviews." And another said, "I think I have only been there twice in four years for a review." Though they also said, "If there is a meeting they tell me about it and I'm included."

We discussed the mixed feedback we received with the registered manager who provided us with a review schedule which demonstrated that a number of planned reviews had now taken place or were scheduled in. We were also provided with copies of people's personal development plans (PDPs) which the service had completed with people prior to organising their reviews. PDP's give people the opportunity to express their views on their care and support and talk about any future goals or identified needs in preparation for their formal review meeting. We were also provided with several examples of reviews that had taken place. We found these were comprehensive and documented people's thoughts and wishes as well as the views of people's families or representatives who were also included in the review process.

Despite some inconsistencies in terms of formal annual reviews, we saw that people were very much included in regular ongoing reviews of their care and support. Written records showed that people had regular monthly meetings with their key worker to discuss their satisfaction with their care and support. Subjects discussed included their personal development plan, activity choices, health, dress, money, food choices, family and trying new things. A person told us, "[staff member] is my keyworker, they are very nice, and they always ask me if everything is ok."

Aside from the scheduled monthly meetings people were also included in discussions and decisions about their everyday lives on a day to day basis using a system of recording called 'Involve Me'. Staff used this system to record conversations between themselves and people about a range of everyday topics. This provided an opportunity for people to talk about anything they wanted to and was also used as a way to support people to raise concerns or talk about any changes they would like to make about their care and support. This method was also used when the service wished to discuss issues with people to demonstrate that they had made every effort to obtain people's input and work with them rather than making decisions about people. We reviewed several examples of completed 'Involve Me' forms which were held in people's care plans and saw they were used to record decisions such as what people wanted to do on any particular day, discussions about proposed changes to medication and choosing activities and holiday destinations. In all the examples reviewed, we saw that staff had used appropriate methods of communication and people's

viewpoints were clearly expressed including how they felt about the outcome of any discussions. People had signed the documents evidencing their involvement.

During our visit we reviewed the care records of four people. The care plans were written in a personalised way which means they were unique to that person. The information held included family information, how people liked to communicate, their nutritional needs, likes, dislikes, what activities people liked to do and what was important to them. There was a section called 'how to support me' which talked about peoples routines and how they would like their care and support provided. The information recorded was thorough and provided detailed guidance for staff on how to support people safely and in a way that met their needs and preferences.

Staff we spoke with demonstrated a very good awareness of the information held in people's care plans and they used this to provide person-centred care. Person-centred care means care that is tailored to each individual. Staff understood how to deliver care and support that was person-centred. One staff member told us, "It's about recognising that every person is different and what they need is different so we treat everyone individually; focus on one person and their needs." All of the staff we spoke with were able to discuss in detail people's likes, dislikes, interests and hobbies and preferred routines.

We received positive feedback from professionals regarding the delivery of person-centred care by the service. A social care professional who told us, "Their approach with my client has been person-centred and they appear to understand his needs well." Of particular note, was an example provided by a relative about the person centred approach taken by the service. They told us that their family member had unusual sleeping patterns which meant they liked to eat their main meal between 3AM and 5AM in the morning so the person's keyworker made them their dinner at this time of the day to meet their individual needs.

A person-centred approach was also taken in matching people up with staff who became their keyworkers. Staff were recruited from diverse backgrounds and consideration was given to people's beliefs, cultures and goals and aspirations when matching them with staff. For example, one person had expressed a desire to learn to read so they were paired with a member of staff with a teaching background. We were advised that in the six months the staff member had worked with this individual and they had now learned how to read.

The service was responsive to people's changing needs and supported people to lead meaningful and fulfilling lives. Staff member told us how they supported people to pursue activities of their choice. We saw that people were supported to enjoy a range of educational, social, creative and physical activities in their home and in the community, for instance, arts and crafts, swimming, gardening, library visits, social events, shopping and the gym. One person said "I go pottery which I like and I'm going to start a voluntary job soon, they are helping me with that; we also go to a disco, I like meeting people." Relatives told us that their family members lived full lives. One relative told us, "There was a time when [person] didn't have a lot to do but now they go out in the community, they go to college, to the gym, to the park and shopping and at home they do jobs." People were supported to go on holidays of their choosing. We saw that a holiday had already been booked for 2017.

People were supported to do the things they enjoyed. We saw that people had a structured weekly activity plan which included something for them to do every day including weekends. However if people did not want to do any of the activities, they could choose to do something else. Staff told us that whilst most day activities were planned, others particularly in the evening just happened if people decided they wanted to go out. One person told us, "The best thing about living here is that I get to do what I want to do."

The service had a complaints policy and there were systems in place to deal with formal complaints. We saw that the registered manager dealt with complaints in an open and transparent manner, investigating issues thoroughly and demonstrating accountability. The registered manager advised that they had no open complaints at present. We asked people and relatives if they knew how to make a complaint and whether they felt complaints were dealt with satisfactorily. One person told us, "If I had a complaint I would talk to [service manager] but I haven't had to do that." A relative told us, "I have made a complaint before, they dealt with it very well, I told [registered manager] and they addressed the issues." However, one relative told us, "Some complaints are not responded to by Clearwater." The registered manager advised us they were in regular dialogue with this relative via email working at addressing their ongoing concerns as they arose.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe. The registered manager was supported by two service managers who had daily oversight of the various properties where people that received care and support lived. Together the three managers made up the management team and had responsibility for the day to day running and oversight of the service.

The management team were visible within the service and worked hands-on supporting staff and working with service-users. The service managers regularly visited each property where services were provided to discuss any local issues and to obtain the views of people and staff. The registered manager also visited people in their homes to complete observations of staff practice and monitor the quality of the service people received. Staff told us they received constructive feedback from the registered manager which helped them make any necessary improvements to their practice.

Staff told us that they felt very well supported by the management team. One staff member told us, "The management team are fantastic, very approachable; the service managers come to see us three to four times a week; [service manager] says if there are any problems no matter what always call me, even at weekends." Because staff found the management team to be very approachable this meant that they felt confident to report any whistle-blowing concerns as felt they would be dealt with fairly without recrimination.

Staff, relatives and professionals spoke positively about the registered manager and felt they managed the service well. However there were some mixed views expressed regarding the role of the service managers. One relative told us; "[service manager] is my first point of contact; he investigates any concerns that the family raise. He has a pleasant manner and gets on well with [person]." However two relatives we spoke with expressed a lack of confidence in the new management structure. The main criticism levied by relatives was regarding a lack of communication. Three relatives told us they would like to be given more information. Comments included, "I know who the new service manager is, I would appreciate it if they could communicate more with me about [person], I would like a regular update." And, "Communication from [property address] is non-existent; we have to ring up to check on issues." And, "I would like to know more about what [person] is up to, I used to get more information from previous staff."

Despite concerns raised by some relatives about a lack of communication and information sharing, we saw that the service included relatives in the running of the service through the use of satisfaction surveys which were sent out them twice yearly to encourage communication and request feedback. The responses from surveys generated an action plan which was then shared with people and their families. We looked at the most recent survey and saw that the concerns about a lack of communication between the service and relatives had been raised. We saw that an action plan had been generated which instructed that the service managers should contact people's appointees to check they were getting the information they wanted when they wanted it. However, the feedback we received demonstrated that some relatives, who were not necessarily 'appointees' felt that communication and information sharing about the progress and wellbeing

of their family members could be improved upon and this was not covered in the action plan.

We recommend that the service evaluates its current systems and practices of information sharing and communicating with people's relatives and/or representatives.

People who used the service also received a satisfaction survey twice a year and actions were generated and completed in response. For example, we saw that where a person had said that they did not understand what a review was, the service worked with speech and language therapy (SALT) to develop a social story to help the person understand better and be more involved at meetings and reviews. A social story is a short description of a particular situation, event or activity, which includes specific information about what to expect in that situation and why.

The service also sent out a survey to professionals twice a year. However, the registered manager told us this had not proved to be an effective way of obtaining professional views on the quality of the service and they had therefore introduced a comments book which was kept at each property where people lived to encourage professionals to leave feedback about the service.

Staff said they were included in the running of the service and were sent a yearly staff survey. We saw that the service had acted on feedback received from staff, for example, by introducing an employee of the month scheme. Staff were also involved in the running of the service through attendance at staff meetings. We looked at the minutes of staff meetings and saw that they were used constructively to share information and where action points were raised a designated person was identified to take responsibility for the actions to ensure issues were dealt with. The meetings were also used to discuss people's care needs and staff practices were which helped to keep staff up to date with current best practices and new developments or initiatives. Staff were positive about the team meetings and level of support provided. One staff member said, "We have team meetings, the management team are fantastic, I feel listened to; They ask about any concerns we have with people and staff and training."

We found that the culture of the service was one of respecting people as individuals, promoting independence and empowering people to make their own choices. Written records demonstrated the emphasis the service placed on advocating for the rights of people to make decisions. Our discussions with and observations of staff showed that staff were aware and put into practice the services' vision and values.

The registered manager provided strong leadership and had a clear direction for the service which included promoting learning and development for staff and a strong focus on positive outcomes for people who used the service. For example, they had signed up the management team to complete a positive behavioural support (PBS) course with the plan to cascade the knowledge to the rest of the staff team for the benefit of people who used the service. PBS is considered best practice in managing behaviour that challenges. The registered manager told us, "This course will give managers the detailed understanding of how to structure their analysis and response to behaviours; we are doing this for staff to give them greater insight and reduce the risk of behaviours being taken personally"

We saw that any incidents or issues of concern that arose were used constructively to learn from and this learning was shared with all of the staff to develop staff skills and improve the quality and safety of the service. For example, we saw that where the service had identified that a person did not like it when staff worked with other people. An action plan was put in place not to allocate the same staff all of the time to the person so that they would not expect the staff to work just with them.

Quality assurance systems were in place to monitor the safety and quality of the service being delivered. We

saw that the management team completed a comprehensive range of audits to assess and monitor the service and drive improvements. Systems were in place to ensure clear lines of accountability and managerial oversight. The management team were responsible for generating weekly, monthly and quarterly reports which included reviews of accidents and incidents and safeguarding's. These were sent to the Group Supported Living Manager, Operations Director and other members of the Senior Management Team. All incidents are reported to the Board monthly or as necessary. This ensured robust oversight of the service at the highest levels to monitor whether any improvements were required and that any identified actions had been completed.