Accomplish Group Lifestyles Limited

Isle of Wight Supported Living

Inspection report

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Date of inspection visit:
10 August 2018
14 August 2018

Date of publication:
10 September 2018

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

Isle of Wight Supported Living Service is a domiciliary care agency. It provides care and support services to people living in their own homes in the community. Not everyone using Isle of Wight Supported Living received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of the inspection, Isle of Wight Supported Living were providing the regulated activity of personal care for 28 people. Our inspection was based on the care and support provided to these people, each of whom received a variety of care hours from the service depending on their level of need. People had a learning disability or autism and were living in individual supported living flats or shared houses; they required support to enable them to retain a level of independence.

This inspection was conducted between 9 and 14 August 2018 and was announced. We gave the provider two working days' notice of our inspection as we needed to be sure key staff members would be available.

We last inspected the service in June 2017 when we did not identify any breaches of regulation, but rated the service as 'Requires improvement'. Following that inspection, the registered manager told us the improvements they planned to make. At this inspection, we found improvements had been made.

Individual and environmental risks to people were managed effectively.

Staff supported people to take their medicines in a safe way. Staff followed infection control procedures and used personal protective equipment when needed.

Staff understood their safeguarding responsibilities and knew how to identify, prevent and report abuse. The registered manager reported incidents appropriately to the local safeguarding authority and conducted thorough investigations.

There were enough staff available to complete all care and support required. Robust recruitment procedures were in place to help ensure that only suitable staff were employed.

People and relatives were complementary about the staff and the quality of care they provided. New staff completed an effective induction into their role and experienced staff received regular refresher training in all key subjects. Staff were appropriately supported by team leaders and managers.

Staff followed legislation to protect people's rights and sought consent before providing care or support to people.

Care plans were informative, up to date and reviewed regularly. People received personalised care from staff

who understood their individual needs well. Staff were flexible and adaptable when people's needs or wishes changed.

Staff were responsible for supporting people to meet their nutritional needs, they encouraged people to maintain a healthy, balanced diet based on their individual needs and preferences.

Staff supported people to access healthcare services where needed.

Staff were caring and compassionate. They built positive relationships with people, encouraged them to be as independent as possible and involved them in decisions about their care.

Staff treated people with dignity and respect and protected their privacy during personal care.

People and relatives had confidence in the service and felt it was managed effectively. They knew how to raise a complaint and felt they would be listened to.

There was a clear management structure and an effective quality assurance process in place. The provider sought and acted on feedback from people.

There was an open and transparent culture. The registered manager notified CQC of all significant events and understood their responsibilities under the duty of candour requirements.

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.

Individual and environmental risks to people were managed effectively.

There were enough staff to meet people's care and support needs. Recruitment practices helped ensure only suitable staff were employed.

Where the service supported people to take their medicines, this was done in a safe way by trained staff.

Care staff had received safeguarding training and were clear about their safeguarding responsibilities. The provider was aware of their responsibilities and had reported safeguarding concerns when required.

There were appropriate systems in place to protect people by the prevention and control of infection.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses and manage emergency situations.

Is the service effective?

Good

The service was effective.

Staff acted in the best interests of people and followed legislation designed to protect people's rights.

The registered manager conducted assessments of people's needs before agreeing to support a new person. Staff supported people during their transfer to the service and if they required care at other settings such as acute hospitals.

People received effective care from staff who were competent, suitably trained and supported in their roles.

Staff were responsible for meeting people's nutritional needs, they supported people to maintain a healthy, balanced diet

based on their individual needs and preferences.

Staff used technology to enhance people's care and promote independence.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They built positive relationships with people and promoted their independence.

Staff protected people's privacy and respected their dignity.

People, and family members where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person. Care plans were reviewed regularly and staff responded promptly when people's needs changed.

Staff were committed to supporting people to receive compassionate end of life care should this be required.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff had confidence in the service and felt it was managed effectively.

There was a clear management structure in place. People benefitted from a service where staff were motivated and happy in their work.

A quality assurance process was in place to assess and monitor the service. The provider sought and acted on feedback from people.

There was an open and transparent culture and the registered manager notified CQC of all significant events.

Isle of Wight Supported Living

Detailed findings

Background to this inspection

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

The inspection was announced. We gave the provider two working days' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available. The inspection was conducted by one inspector. The inspector visited the service's office on 9 and 14 August 2018 to see the registered manager and office staff and to review care records, staffing records, policies and procedures.

Before the inspection, we reviewed information we held about the service including notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law. We also considered information the provider sent us in the provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people's relatives by telephone and visited eight people in their homes. We spoke with the registered manager, three team leaders and six care workers. We looked at care records for five people. We also reviewed records about how the service was managed, including staff training and recruitment records. We received feedback from one healthcare professional.

We last inspected the service in June 2017 when did not identify any breaches of regulation, but rated the service as 'Requires improvement'.

Good

Is the service safe?

Our findings

People told us they felt safe with staff. We asked people if they felt safe. One person said, "Yes safe." Another person said, "Oh yes, the staff are good, I'm safe here". Another person who was unable to respond verbally smiled and indicated that they felt safe with staff. All family members confirmed they felt their relative was safe and that staff acted to keep them safe.

People were protected from individual risks. Team leaders completed assessments to identify any risks to people using the service or the staff supporting them. These included environmental risks in people's homes and risks relating to the health and support needs of the person. When risks were identified, people's care records detailed the action staff should take to minimise the likelihood of harm occurring. For example, one person was at risk when traveling in cars. Action had been taken to ensure a suitable safety harness was available and used on all occasions. Some people were at risk of choking on some foods. Action had been taken to ensure they received only foods in a suitable format to ensure their safety. Staff were aware of these risks and described how they supported individual people to keep them safe. Risk assessments were kept under review and amended as required.

Records confirmed that the registered manager had reported all allegations of abuse to the local safeguarding authority and had cooperated fully with all investigations. The registered manager shared details of the actions they had taken. These showed concerns had been comprehensively investigated and, where necessary, had resulted in prompt action to protect people from further risk of harm. Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Training records showed all staff had completed safeguarding training which was covered during induction.

There were appropriate systems in place to protect people by the prevention and control of infection. Where able, people were supported to complete a cleaning schedule each week to help control the risk of infection. Accommodation visited looked clean and staff had completed infection control training. They had access to personal protective equipment (PPE), such as disposable aprons and gloves, and we saw they used this appropriately during our visits. Infection control and cleanliness of accommodation was included with audits completed by the service.

Where the service supported people to take their medicines, we found this was completed in a safe way. People told us they received their medicines as prescribed and could requested 'ad hoc' pain relief such as paracetamol should this be required. Care files contained information as to medicines people were prescribed and how they liked to take these. Staff supported people to have an annual health check which included a review of prescribed medicines to ensure these remained appropriate for the person.

The provider had clear procedures in place to train and check the competence of staff administering medicines. Care staff confirmed they had completed medicines management training and had their competency checked before they administered medicines on their own. Records showed all staff had their medicines administration competency reassessed yearly as required by best practice guidance. A team leader told us that if an error occurred supervision was held and staff may be required to complete training

again. Appropriate systems were in place to obtain, store and dispose of medicines safely. We checked a sample of medication administration records, which were used by staff to record when they had administered medicines. These confirmed that people had received their oral medicines and topical creams as prescribed.

Appropriate arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for three newer members of staff showed the service had operated a thorough recruitment process in line with their policies and procedures to keep people safe. For example, Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with vulnerable people had been completed. Staff files included application forms, previous employment history, health declarations and references. New staff confirmed they had undergone a comprehensive recruitment process and had not commenced employment until all checks had been completed.

Everyone receiving a personal care service required 24-hour support with staff available at all times. Staffing levels within individual houses were determined by the number of people living there and their needs. Core hours were provided in each house and individual people received the level of support that had been assessed as needed by the local authority. The registered manager told us the service was almost fully staffed and, although agency staff were used this was now only required on very rare occasions. Family members told us they felt staff were consistent and they usually saw the same staff when they saw their relative. People told us they were supported by consistent staff and in some houses staff had worked with the same people for many years. We viewed duty rosters within several houses which showed that any additional shifts required by staff holiday or ill-health were usually covered by existing staff or staff from other houses who knew the people well. Where agency staff were used the registered manager stated they requested the same staff wherever possible. This meant people received the care they required from staff who they knew and who knew them and what support they needed.

The registered manager encouraged staff to report concerns and safety incidents. There were processes in place to enable them and the provider to monitor accidents, adverse incidents or near misses. Records viewed showed that a comprehensive, timely investigation had occurred and relevant professionals such as health or the local authority had been informed. The registered manager said they looked to identify any potential learning or improvements required to promote safety and reduce the risk of future incidents.

The service had a business continuity plan in case of emergencies and within individual houses we were told of their plans for emergencies. This included eventualities such as the risk of severe weather which may prevent staff arriving for work. All staff were clear that they would not leave a house until their replacement staff had arrived. For other emergencies, such as fire there were personal evacuation plans in place, systems to detect fires and arrangements for staff as to what they should do. Staff had completed first aid training and were aware of how to respond should a medical emergency occur. Staff told us about actions they had taken during the recent very hot weather which included ensuring people wore suitable clothing and had sufficient cold drinks to remain adequately hydrated.

Good

Is the service effective?

Our findings

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Since the last inspection, the registered manager had implemented new procedures to ensure that people only received care and support with their consent or with the consent of a person with legal authority to do so. We saw capacity assessments and best interests decisions had been made, where needed, in conjunction with family members and other professionals where appropriate.

The registered manager and care staff demonstrated an awareness of the MCA and understood how this affected the care they provided. They understood when they needed to complete mental capacity assessments and make best interest decisions. Meetings had been held and the procedures in place to protect individual people were necessary to keep them safe. Staff had undertaken training in the MCA and described how they offered choices to people, were guided by their responses and were clear about the need to seek verbal consent from people before providing care or support. Staff were aware of the actions they should take if people were making unsafe decisions which they could not fully understand the consequences of. Where able, people had signed consent forms such as in respect of the use of their photograph by the provider.

For individual safety reasons some people required a high level of support when accessing the community and some restrictions were in place. These included the use of specialist harnesses for cars, door alarms to alert staff that people may be leaving their flats at night and procedures that ensured people would always be supported appropriately when out in the community.

The registered manager assessed people's needs before agreeing to support a new person within the service. The registered manager said they considered not only if they could meet the new person's needs but how this would affect the people already living in identified shared accommodation. One person was in the process of moving into one shared house. The process was explained by the registered manager and relevant records viewed. Visits had been arranged and were ongoing to ensure a gradual and smooth transition from the person's current service.

People's care plans included information that could accompany the person if they needed to be admitted to hospital. This included a range of information that would help ensure hospital staff understood the person's communication and personal care needs as well as detailing any medicines prescribed and previous health needs. Staff also told us they would accompany people to hospital. They gave an example of when this had occurred in an emergency and an off-duty staff member had been contacted to provide support for people whilst the on-duty worker was at the hospital with the injured person. Where required, staff also accompanied people to routine healthcare appointments to provide support and aid communication. This was confirmed by people and staff we spoke with.

People's health and personal care needs were well met because staff knew people's needs and could describe how to meet them effectively. A health professional told us they felt staff understood people's health needs. Family members told us they felt people's personal care needs were always met and they were kept informed about any changes relating to health needs. Discussions with staff showed they understood people's health needs and medical advice had been sought when required. For example, in one house a staff member told us how they had requested a doctor's visit when they had noted a skin rash whilst providing personal care. Care files contained health action plans which included information about people's previous health needs and showed people were supported to attend regular medical, dental and optician appointments. Staff were aware of the action they should take if a person was unwell. Care staff confirmed they had received first aid training and additional training to meet the needs of any specific health needs individual people may have.

People told us they were happy with the meals they received and confirmed they had choice and were involved where appropriate in shopping and meal preparation. People told us staff helped them prepare their meals which we saw occurring when we visited some houses. Care staff involved in the preparation of food told us they would always ask the person what they wanted. Care plans contained information about any special diets people required and about specific food or drink preferences and records of food and drinks people received were kept. Care staff were aware of people who required a specific diet such as those who should avoid certain foods or receive their food in a specific texture. People were receiving a varied diet that met their individual preferences with staff helping people to make healthy decisions. Care staff and training records confirmed staff had completed food hygiene training.

People were positive about the competence of staff and the quality of care and support they received. This was demonstrated by people confirming they felt safe and happy with care staff. New staff completed an effective induction into their role. This included an initial training programme, together with 'shadowing' where they worked alongside experienced care staff until they felt confident and competent to work unsupervised. New staff, including those who were more experienced and those who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Existing staff received regular refresher training in all key subjects and were supported to undertake other training relevant to their role, such epilepsy management. The registered manager told us they had funding for staff to complete formal care qualifications and were in the process of identifying staff for whom this would be appropriate.

The provider had an autism specialist advisor who could provide care staff with individual specialist advice and support to ensure that where people had a diagnosis of autism their specific needs could be understood and met. A care staff member told us about a visit from the autism specialist advisor and that guidance had been provided to enable staff to better support the person.

Staff told us they also felt supported in their work. One staff member said, "I can always go to my team leader; they are here a lot of the time." Another staff member said, "There is always someone there for advice, always a team leader on call." Team leaders confirmed the on-call arrangements and that they felt supported by the registered manager.

The provider's policy required staff to receive support from a supervisor in the form of a one-to-one supervision every six to eight weeks. Staff told us, and records confirmed, that supervisions were being completed on time as required by the provider. The process was structured and records viewed showed these covered a range of relevant areas and included identifying actions required by both the supervisor and supervisee when necessary. All staff who had worked at the service for more than a year had received an

annual appraisal to discuss their performance, feedback any concerns and discuss any training needs.

Staff used technology to enhance people's care and promote independence. Care staff described how they had trialled a communication device for a person who did not use spoken language. Another person used an electronic system to provide verbal prompts to enable the person to complete a range of daily tasks with greater independence. Where people lived in their own flats and did not have individual staff overnight, alarms were in use to alert staff that the person was leaving their flat and may be at risk. The service was introducing computerised recording of daily actions. Care staff showed us how the system was used and we saw in the office that this enabled the registered manager to check information and ensure people were receiving the level of care and support they required.

Good

Is the service caring?

Our findings

People's needs were met by staff who were caring and compassionate. People described staff as "Nice" and "Kind". One person told us, "Staff are my friends. I like them." A relative told us they felt staff had a good rapport with a person adding "[Name of person] especially likes [name of staff member] and they get on well together." A healthcare professional described staff as "clearly caring and understanding of people with complex needs".

We saw that people were supported to be appropriately dressed and well-presented which promoted their dignity. Conversation between care staff and people was easy, comfortable and familiar showing that staff had a good knowledge of people's likes and dislikes. During our home visits, we observed positive interactions between staff and the people they were supporting. Staff clearly knew people well and had a good rapport. For example, in one house people returned from a food shopping trip. Everyone was helping to put away the shopping and staff were thanking people for their assistance. One person asked us if we would like a hot drink. Staff told the person they were very thoughtful. Positive comments such as these and acknowledging the help people provided promoted positive self-esteem and self-worth for people.

Staff supported people to build and maintain relationships with people who were important to them. For example, one person told us they could have friends visit them and staff members were supporting a person to visit a close relative regularly. Staff members were aware of people's family members and told us how they involved them where appropriate in special events and when specific decisions the person was unable to make were required. Staff supported people to attend clubs and activities where they could meet friends and enjoy social occasions with them. It was evident all people were supported to have active lifestyles and were members of various social clubs and groups within their local community. Care staff facilitated additional events and we were told about local events people had enjoyed. Care staff were flexible and would work different hours to support people to attend evening or specific activities. For example, one person told us they had enjoyed attending a local music festival. People were supported to enjoy holidays.

We observed and heard staff treating people in a dignified way and with respect. A staff member told us, "I treat people like I would want to be treated." Another care staff member told us they treated people how they would want a family member to be treated should they require a care service. We saw one person who was in a communal area starting to remove an item of clothing. The staff member responded promptly to protect their dignity and understood that the person was communicating a need to them which they proceeded to respond to.

The registered manager explored people's cultural and diversity needs during pre-service assessments and included people's individual needs in their care plans. Care staff were aware of people's individual needs and how they liked these to be met. Care plans contained information about people's religious and spiritual needs and where present how these should be met. People could personalise their homes and we saw these reflected the occupant's preferences. Some people were in the process of moving to a new house. They had been supported to visit the new house and select their bedrooms. The registered manager described how staff were supporting people to choose colours for curtains and other items of decoration.

People and relatives told us they were involved in discussing and making decisions about the care and support they received; for example, a family member told us they had been involved in a review of their relative's care plan. People were also involved whenever their care and support needs were reviewed and their views were recorded in the care records. Care staff described how they supported people with complex needs to make day to day decisions. One staff member said "[Name of person] can choose between two items of clothing if you show them. They will touch the one they want." Staff understood people's communication and what they were requesting. One staff member said "If [name of person] wants a coffee they will go into the kitchen and get a cup out of the cupboard." The staff member demonstrated this and said, "I know what he is saying and so I make him a drink."

Staff encouraged people to be as independent as they could be. Staff understood what people could do on their own and what they needed assistance with. For example, staff explained how they assisted one person to get ready for a shower by organising toiletries and towels and adjusting the water temperature. They then left the person to shower independently whilst remaining in the general area should support be required. In one house a staff member explained that a person liked to make their own way by bus to the bank but they would meet them there to support them to complete financial transactions then leave the person to shop and make their own way home. These examples demonstrated that staff only undertook tasks for people which they were unable to do themselves, thereby promoting independence and self-esteem for the person.

The registered manager and staff recognised that it was important for people to have continuity of care staff. People told us there was a high level of consistency in the staff that supported them. Care staff told us they were assigned to work in specific houses and most staff we spoke with had worked for the service for more than a year and many for considerably longer. When new staff were employed they undertook shadowing shifts to enable them to get to know people before providing care for them. This meant people received care from staff who knew them and how they liked to be cared for. Care staff described how they could identify if people were in pain through behaviours and how another person would take their hand and point to what they wanted. We saw care staff communicating effectively with people demonstrating that they valued people's views and opinions. The service had links with and staff knew how to access advocacy support if this were required.

Information regarding confidentiality, dignity and respect formed a key part of the induction training for all care staff. Confidential information, such as care records, was kept securely within the registered provider's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected and restricted to staff who would require this information. Where records were kept within shared houses these were also only accessible to those who should have access to them.

Good

Is the service responsive?

Our findings

People received a highly personalised care and support service from staff who understood their needs well. One person said of the staff, "I can do what I want to do." Another person told us, "I can decide [what time I get up or go to bed and what I do]." A further person, when asked if they were happy with the way they were cared for, indicated they were by nodding their head and smiling. Family members told us they had been included in discussions about how their relatives care should be provided and that reviews were held to which they were invited.

People living in the supported living flats and shared houses were supported to lead active, fulfilled lives. People told us about a holiday they had been on and about recently attending a music festival. A staff member told us how they could be flexible. They gave an example that a person had wanted to go out that morning and as other people living at the shared house had been out or receiving individual support hours they had been able to go out for a walk and take breakfast in a café. Team leaders told us they could be flexible as to when individual support hours were provided to enable any health or social appointments to be kept.

Care was centred on the individual needs of each person. Most people had been living at their accommodation for many years and all had a plan of care in place. Each person's care plan contained information about their specific needs and how they wished them to be met. The information was available within the person's home and in the agency's office. A record of care provided was kept for each person. Records were kept daily including where necessary,
food and fluid intake, medicines, activities, and personal care provided. We saw that when people required emergency medical treatment this was promptly provided. A person had had a fall whilst at a social club. The staff member had arranged for another staff member to support people and attended the hospital with the person to enable a full assessment and treatment of injuries. This showed staff could meet people's usual routines and respond when changes were required.

During our visits we saw staff supporting people in a personalised way and staff were clear about the importance of taking a person-centred approach to providing care and support. Care plans were reviewed monthly or if the person's needs changed. Records of the care and support provided were up to date and confirmed that people had been supported in accordance with their care plans.

The registered manager told us they were committed to ensuring that, if the situation arose, people would receive a comfortable, dignified and pain-free death. Most people receiving the service were younger adults, for whom discussing end of life care was not a priority. The registered manager said that, should there be a need, they would aim to continue to support people within their own homes as far as this was possible. They were aware of how to access support from health services including the learning disability community team, hospital liaison nurse and the local hospice. They also stated that additional support would be provided for staff and other people living with the person.

People told us they knew how to raise a complaint and said they would "talk to staff". A staff member told us

how they had supported people at one shared house to make a complaint to the housing association about an issue with a neighbour. The service had a policy to deal with complaints, which included details of action people could take if they were not satisfied with their response. The complaints procedure was in a suitable format describing the steps to take and included pictures and contact numbers of the people to contact. This had been provided to people. The registered manager said no complaints had been received since the previous inspection. Should complaints be received there was a process in place which would ensure these were recorded, fully investigated and a written response provided to the person who made the complaint.

Good

Is the service well-led?

Our findings

People, relatives and staff felt the service was organised and managed well. One relative told us they were aware of how to contact the team leader or registered manager (who they could name) if they needed to do so. Another relative told us "I go in to see [name of relative] most weeks. They know me well and if I need to I talk to the care staff. I do know the manager for [name of housing scheme]. I could go to them if I needed to." A staff member confirmed the registered manager had visited the supported living house the previous week and said if they had any problems they knew they could email them. People, relatives and staff all said they would recommend the service to a relative or friend in need of this type of care.

Care staff told us they enjoyed their work and were motivated to support people to lead fulfilled lives. The registered manager stated their goal was to ensure people could "Live the life they want to live". They identified to achieve this they needed to develop staff and give them the tools to do their jobs. The registered manager said the provider's philosophy was to "make every day amazing" and for people to "achieve what they want to achieve".

The registered manager told us that since the previous inspection the provider had introduced more formal processes for monitoring the quality of the service. New computer systems had been introduced including a 'shared drive' which enabled the registered manager and senior managers for the provider to review information about the service. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help identify shortfalls in service provision so the provider can act to drive improvement and promote better outcomes for people. Regular audits were completed in relation to each aspect of the service such as people's medicine administration records, care plans, staff supervision and training. The registered manager told us team leaders were required to audit aspects of their service monthly. They were also required to record information about events which had occurred in the service, such as any accidents and incidents which were then reviewed by the registered manager and included within the provider's on-line quality monitoring systems. They explained this information was also analysed by the provider's quality team to enable them to identify any themes or trends which were then fed back to the registered manager for them to take action. The provider's quality monitoring team also undertook formal audits covering all aspects of the service. We viewed the audits completed by team leaders and the registered manager which showed that there had been an ongoing improvement in the overall quality of the service as assessed by the provider's quality monitoring team. The manager showed us the service's compliance statistics which were consistently now almost 100per cent indicating that the service was meeting the provider's targets for quality assurance. These covered areas such as training, staff support, audits completed and reviews of care plans.

The provider had a clear management structure. Each shared house or accommodation unit had a team leader who also worked on some occasions as care staff within their designated service. This meant team leaders knew and understood people's needs and could directly monitor staff and the quality of service provided for people. The registered manager told us they were supported by the provider's organisational structures and had an identified area manager who monitored their performance and provided ongoing support for them. In addition, the registered manager could access other support from the provider's

organisational teams. For example, the provider had a dedicated human resources team who could give advice and guidance in all matters relating to managing staff. A training department helped ensure staff received all
necessary training and a policies team ensured the service's policies and procedures kept up to date with changes in best practice guidance. An autism specialist advisor was also available to support staff and people living with this diagnosis. The registered manager was positive about the support they received from the provider's management team and organisation teams which they could contact directly when required.

Feedback on the quality of the service provided was sought from people, relatives and staff on an individual and on-going basis. The provider was in the process of sending out surveys to staff and people to gain their views about the service. There were also plans to send surveys to other stakeholders such as relatives and external health and social care professionals. Most shared houses held a weekly meeting to enable people to make specific decisions about where they were living and to be kept informed about any changes which may be occurring. One person told us they also discussed any menu choices and activities they would like to do in the coming week during house meetings.

There was an open and transparent culture. The service's previous rating was prominently displayed in the reception area of the service's office. Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. The registered manager was aware of what needed to be reported to the local authority under safeguarding and to CQC as a formal notification. Records showed that notifications about significant events were reported to CQC as required. The registered manager understood their responsibilities under the duty of candour policy which required them and staff to act in an open way if people came to harm. The registered manager was clear about how and when it should be used. Staff were aware of the provider's whistleblowing procedures and told us they would not hesitate to raise any concerns they had about poor or unsafe practice. One staff member told us how, when another staff member had raised a concern, this had been investigated appropriately by the management team. Care staff were also aware of how to contact senior staff within the provider's organisation and external professionals such as the safeguarding team should the need arise.