

Positive Steps (Care Services) Limited

# Positive Steps (care service Limited)

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on 17, 29, 30 November and 8 December 2017 and was unannounced. At the last comprehensive inspection on 16 May 2016 we rated the service as good. At this inspection we found the service is now rated requires improvement.

The service provides care and support to younger people with a learning disability living in two 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

There was a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Staff were knowledgeable about how to report poor care practice and suspicions of harm. Information and guidance about how to report concerns, together with relevant contact telephone numbers was displayed as a prompt to staff, people who used the service, and their visitors to refer to. However, the registered manager had not notified the CQC of a safeguarding concern that they were legally obliged to notify us of.

Pre-employment checks were in place to make sure that new staff were considered suitable to work with the people they were supporting. However, the individual decision making process carried out when a query arose during these recruitment safety checks was not always documented.

People were assisted to take their medication as prescribed. However, 'as required' medication lacked sufficient information and prompts for staff on 'how and when' the 'as required' medication should be given to a person needing this support.

Processes were in place and followed to make sure that infection control was promoted and the risk of cross contamination was reduced as far as practicable.

Staff were available to support people's individual needs in a caring, patient and respectful manner.

People's privacy and dignity was maintained and promoted by the staff supporting them.

People and their relatives were given the opportunity to be involved in the setting up and review of their individual support and care plans. However, people's care and support plans and risk assessments did not always contain sufficient detail as guidance and prompts for staff, for example when a person was at risk of self-harm or in line with external healthcare professionals input and guidance.

Staff encouraged people to take part in activities and trips out into the local community to promote their social inclusion. People's friends and family were encouraged by staff to visit the service and were made to feel welcome.

People's health and nutritional needs were met. People were assisted to access a range of external health care professionals and were supported to maintain their health and well-being.

Staff were trained to provide effective care which met people's individual needs. The standard of staff members' work performance was reviewed by the registered manager through supervisions, and competency checks.

Compliments about the care provided were received and complaints were investigated and action taken to make any necessary improvements. However, the provider's complaints policy was not available in an easy read or pictorial format that meant that more people could have access to this policy and understand it.

The registered manager sought feedback about the quality of the service provided from people, their relatives, and staff. There was an on-going quality monitoring process in place to identify areas of improvement required within the service. Where improvements had been identified, actions were taken to make the required improvement. However, not all areas for improvement found during this inspection had been identified by the providers quality monitoring process.

Learning from incidents took place to reduce the risk, as far as practically possible, of recurrence. However, the actions taken as a result of learning were not always documented.

Records showed that the CQC was informed of the majority incidents that the provider was legally obliged to notify us of.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Systems were in place to protect people from harm or poor care. Not all safeguarding concerns had been notified to the CQC.

Risks to people were assessed, however information on how to reduce these risks were not always available for staff to make sure that people remained safe.

There was a sufficient number of staff to meet people's assessed needs. However, robust recruitment checks, when a query arose during the check were not always documented.

Processes were in place to ensure that people's medication was safely managed by staff.

### Is the service effective?

**Good** ●

The service was effective.

People's needs and choices were assessed and staff supported people in line with legislation and evidence-based guidance. Consent to care and support was sought in line with legislation. People were not unlawfully restricted.

Staff were supported with training, supervisions, and competency checks and to make sure they were delivering effective care.

Guidance was followed to make sure that people were hydrated and supported with a healthy and nutritional diet.

Staff worked alongside other organisations to deliver effective care and support. People were assisted to have access to external healthcare services when needed.

### Is the service caring?

**Good** ●

The service was caring.

People were treated with kindness and respect when assisted by

staff and people and their relatives were supported to be involved in making decisions about their/their family members care and support needs.

Staff promoted and maintained people's privacy and dignity at all times.

People's visitors to the service were made to feel welcome by staff.

### Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed and staff used this information to deliver personalised care to people that met their needs.

Activities were in place for people to take part in; there were also links with the local community to promote social inclusion.

People's concerns and complaints were listened to and acted upon.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

There was a registered manager in place.

Staff were clear about the good standard of care and support they were expected to deliver.

Monitoring was in place to oversee the quality of the service provided and make any necessary improvements. However, these audits did not identify all areas requiring improvement.

People and their relatives felt involved in the service and were able to give feedback on the service provided.

The registered manager was not always up-to-date with guidance and codes of practice relating to the service provision provided to people with a learning disability.

# Positive Steps (care service Limited)

## **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 prompted by a whistle-blowing concern raised with the CQC. We also raised these concerns with the local authority safeguarding team.

This inspection took place on 17, 29, 30 November and 8 December 2017 and was unannounced. The inspection started on 17 November 2017 and ended on 8 December 2017. We visited the office location within the supported living houses on 17 and 29 November 2017 to see the registered manager, staff and people using the service. We also reviewed care records, staff records, governance records and policies and procedures.

The inspection was carried out by two inspectors.

During the inspection timeframe we looked at information we held about the service and the provider. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. This helped us with this inspection.

During the inspection we spoke with two people who used the service and two of their relatives. We also spoke with the registered manager; a senior support worker and two support workers.

We observed staff that were supporting people to help us understand the experience of people who could not talk with us. We looked at two people's care records and records in relation to the management of the service and management of staff. We also looked at financial records in conjunctions with people's

spending; people's tenancy agreements, and the management of people's medicines. We also looked at compliments and complaints received; staff training records; and two staff recruitment files. During the inspection, on the 30 November and 8 December 2017, the registered manager sent us information around their knowledge of the CQC document 'registering the right support.' They also sent a risk assessment around employing staff whose recruitment checks had a query, a copy of tenancy agreements and an updated risk assessment for a persons assessed risk.

# Is the service safe?

## Our findings

Prior to this inspection the CQC received concerns that resulted in the CQC informing the local authority safeguarding team of the allegations.

Before this inspection the CQC were informed of concerns around the locks on people's bedroom doors. During our tour of Laurel House, we saw that people's bedroom doors could be locked. Staff told us that some people liked their doors locked when out and about and other people liked their door ajar. However, we observed that one of the bedroom doors had a key lock mechanism. This meant that if locked, the room could not be opened on the inside of the door by the person inside of the room, if the key was still on the outside and vice versa. During the inspection period, the registered manager confirmed to us and we observed during our second visit, that this lock had been changed. This meant that the room could be easily unlocked from both the inside and outside if needed. This demonstrated to us that a person could choose to lock their door if they wished to do so, but the door could be easily opened by themselves or staff when needed, for example in an emergency.

Staff had received training on how to safeguard people from avoidable harm and poor care. They confirmed that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff described to us how they would recognise and report concerns in line with their safeguarding training. This included reporting allegations of poor care or suspicions of harm both internally to the registered manager and to external agencies, such as the CQC or local authority. A senior support worker said, "You would follow the employee handbook and alert the [registered] manager or alert the director. If nothing is done, if no one is listening [to you] you would then contact the CQC. [Contact] details of the local authority [safeguarding team] are also displayed on the wall to refer to." Guidance and information about how to report concerns, together with relevant contact telephone numbers were displayed in communal areas. This was for people who used the service, their visitors and staff to refer to if needed. One person, when asked what they would do if they were worried about something or unhappy, told us that they would, "Tell staff."

Although staff told us that they knew how to identify avoidable harm, records showed that staff had failed to identify a potential safeguarding incident. We noted in one of the care records that a person was assessed as being at risk of self-harm. We saw that on the 5 November 2017, staff had found unexplained marks on the person's body. Documents showed that staff had tried to ascertain from the person how the marks had happened but there was no documented record to show that this unexplained injury had been notified to the CQC as a safeguarding concern. We spoke to the registered manager about this during our visit. They confirmed that going forward they would make sure that they submitted the appropriate notifications.

People's relative's told us that they had no concerns over how their family members' finances were being managed by staff at the service. A relative said, "I deal with [family members] money. I have no concerns about how staff support [family member] to spend money. I have three financial accounts [for family member], bills go out, there are direct debits and a certain amount is taken for clothing etc... I can tell if [staff] are overspending or under spending. I have no issues; [staff] keep good financial records."



However, prior to this inspection, the CQC received concerns that alleged that people's money was sometimes being mismanaged by staff. During this visit we looked at financial records held by staff for each individual person's expenditure. The registered manager told us that at Laurel House each week a set amount was deducted from each person's allowance to contribute towards the food bill and maintenance costs. When we asked to see whether people using the service or their next of kin had agreed to these amounts being debited, we were told that this had been agreed verbally and that there was no formal contract in place. The lack of records in place around these agreements meant that people and their relatives did not have a documented record that was a clear and transparent agreement to these deductions. Following a discussion about this with the registered manager on the first day of our visit, they sent a letter out to all relatives and advocates asking them to agree to these debits in writing. One relative confirmed to us, "I have just received a letter [from the provider] explaining [family members] direct debits and I was not aware of this previously. There has never been any financial query – I trust them."

Records for individual expenditure, such as items purchased, car mileage or the cost of external activities was recorded separately alongside the corresponding receipt wherever possible. We noted that some receipts were missing for items where a receipt would have been issued. On speaking to the registered manager and a senior support worker about these missing receipts they told us that staff would be spoken with if they failed to produce a receipt. The senior support worker said, "I am very robust with checking the money [spent] and staff need to explain [to me] if they don't have a receipt." Although, the senior support worker confirmed to us that these conversations held with staff were not documented. This meant that there were not always robust documented financial records held.

The provider carried out checks on new staff to confirm that they were suitable to work with people and of a good character. A staff member said, "Yes I had to have references and a clear [criminal records check] in place before I could start work." Checks included proof of identity; reference checks from previous recent employment; and criminal records checks from the disclosure and barring service (DBS). However, records showed that any queries, such as a person's previous behaviour or gaps in a person's employment history were not recorded as being fully explained. We spoke with the registered manager about this during the inspection. They confirmed that discussion had been had with the potential new staff members prior to their employment but these discussions had not been documented. The registered manager then sent us a generic risk assessment document. This explained the decision making process the registered manager could take when employing a person where there had been a query raised during their employment checks. However, this record was not an individual risk assessment, unique to the person they were employing. It did not detail the individual decision making process that had taken place to ensure that the potential new staff member was deemed suitable. This meant that there was a lack of robust documentation in place which explained these recruitment decisions.

People's relatives told us their family member felt safe at the service because of the care and support they received from staff. One relative said, "[Staff] have good policies in place regarding [family members] safety when she is [in the community] it is two staff to one [person] support." Another relative told us, "The support [family member] receives helps keep him safe. [Staff] never allow him to leave the front door unattended as he would be unsafe." This demonstrated to us that staff had a positive approach to risk by ensuring that people's independence would be promoted, whilst trying to ensure their safety. This included people's wish to access the local community and how this had been planned for and implemented.

Staff said that they adopted a proactive approach when dealing with people's changing behaviours such as behaviours that other people may have found challenging. Staff told us that as a last resort, when a person was going to put themselves or other people at risk of harm or danger, they could use a safe type of restraint called 'team teach'. Staff said and records confirmed that they had been trained in this technique and they

talked us through the process. One support worker told us, "We have team teach [training] re restraint. It teaches you on how to protect yourself and the person [who is becoming agitated]...You link [your arm] through theirs, elbow to elbow, to encourage them to move to a quieter area [to calm down]." This showed us that there were safe measures in place to reduce any harm occurring to people when they were becoming increasingly anxious and agitated.

People's care and support plans were stored securely and contained adequate information for staff to deliver safe care. The majority of people's risks had been identified when they first used the service and as staff got to know them and their individual needs. These risks were assessed to provide individual prompts and guidance for staff to support people and to help reduce the risk of harm. However, we noted that some people's care plans and risk assessments at the Dovedale supported living service contained only limited detail as information for staff. For example, for one person there was little detail about what known triggers made them anxious, how this anxiety would be displayed and what staff should do on these occasions. Staff spoken with were able to demonstrate they knew the people they were supporting well. However, this lack of documented guidance for staff increased the risk of inappropriate care and support being given.

People's assessed risks included, people's communication skills; being out in the community; prescribed medication; travel using public transport; being at risk of becoming anxious; being at risk of bullying; and lack of personal care. However, we noted that a risk of self-harm for a person at the service had been identified but a risk assessment as guidance for staff had not yet been completed. We spoke with the registered manager about this during our visit, who said they would take immediate action to remedy this. They sent us this risk assessment during our inspection.

People's relatives were able to tell us how they had been involved in the management of their/their family member's care records, risk assessments, and review of these. One relative confirmed, when asked if they were involved, "Definitely." Another relative told us, "I am involved in [family members] care decisions and I am involved in reviews of his care alongside his social workers...The [staff] know [family member] really well." This showed us that people and their relatives were involved in decisions around their care.

People had evacuation risk assessments in place to assist them to evacuate safely in the event of an emergency such as a fire. However, the registered manager told us that there was no business contingency plan available for staff to give guidance on how to continue to support people in the event of an emergency having taken place. This meant that there was an increased risk that staff did not have documented information such as where to accommodate people at short notice in the event of such emergency.

Prior to this inspection concerns were raised with the CQC that there were not enough staff to support people at Laurel House during the night. The registered manager told us and staff confirmed that in recent months the staffing levels during the night at Laurel House had increased. A support worker said, "There are now two waking [staff who have to stay awake during the shift] night staff in place. This has been in place for the last six to 12 months." We noted that staffing numbers were established based on people's care, support and dependency needs and that these numbers changed as and when people's needs changed.

People's relatives told us they had no concerns over the number of staff available to support their family member. During this visit we saw that there were enough staff to support people inside of the service [at home] and on trips out into the community. We noted that staff were busy but supported people in an unrushed and patient manner. This showed us there were enough staff to assist the people they were supporting safely.

Relatives of people using the service had no concerns on how their/their family members' prescribed

medication was managed by staff. One relative said how they had raised a concern previously with the registered manager following a medication error. However, they then told us they had confidence in the way the matter had been handled. Another relative told us, "I have no concerns regarding [family members] medication – [staff] have never let it run out." Medication administration records (MARs) looked at showed that medication had been administered as prescribed. Staff told us and records showed that they had training in how to administer people's medication safely. They said that their competency to do this was checked by them completing a skills and knowledge test paper. A staff member also confirmed to us that actions had been put in place to reduce the risk of medication errors. This meant that the provider had systems in place to try to make sure that medicines were managed safely.

Our observations showed that people's medication was locked away, and stored at the correct temperature. However, we saw that there was limited information in place as guidance for staff for people who required assistance with their 'as and when needed' medications. There was a lack of guidance for staff on when a person should be given this type of medication. This meant that there was an increased risk that this medication would not be given when required.

We saw that the service was visibly clean and free from malodours and that soap and hot water was available for staff, people and their visitors to use to wash their hands. A support worker told us that they had enough personal protective equipment (PPE) and cleaning equipment available. They talked us through how they cleaned different areas of the service using different cloths, and different colour mops and buckets to reduce the risk of cross contamination. This showed us that processes were in place to reduce the risk of infection and cross contamination.

Accident and incident records were kept. However, these records did not document the action taken as a result of learning from these incidents and to reduce the risk of recurrence. Staff told us that regular team meetings were held and information regarding any actions taken as a result of incidents that had occurred were discussed. The senior support worker said, "We discuss what went well and what didn't go so well. We do a lot of debriefing with staff to recap on the previous shifts. This is always fed back [to staff] as lessons learnt."

# Is the service effective?

## Our findings

External health and social care professionals visited the service to work alongside staff to achieve effective care and well-being for people being supported in line with up-to-date guidance. A relative told us how staff had worked in conjunction with a dietician to support their family member's weight management. They said, "Staff create good menus that are healthy and take advice from the dietician."

Staff described the training they had undertaken to ensure that they had the right skills, knowledge and experience to provide the individual support and care people needed. They described to us how their training enabled their understanding of their duty to promote and uphold people's human rights by treating them as individuals with equal rights. A staff member said, "We are all working in a profession to look after people and make sure that they get the right care...but the main thing is to help [people] be independent... you use verbal praise [to encourage] positive behaviour."

Staff training included, safeguarding adults and children; moving and handling; medication management; mental capacity act 2005 (MCA) and deprivation of liberty safeguards (DoLS); infection control; autism awareness; learning disability awareness; team teach (restraint); food hygiene and nutrition; and healthy eating. Training also included, health and safety; fire safety and training on health conditions such as epilepsy. This showed us that staff were given training to help them provide effective care and support without discrimination and in line with legislation.

Staff were supported with supervisions, from the registered manager and their competency in providing the right support was checked by the registered manager. A senior support worker told us, "We have supervisions with the [registered] manager every three months where we can talk about any developmental needs, training requests and discuss concerns...You can do extra training and specialist training. I have just done an epilepsy training [course] for a person who is coming to live here who has epilepsy." Staff said that when new to the service they had completed an induction period. This included training and shadowing a more experienced member of staff until they were deemed competent and confident by the registered manager to provide care.

People's individual dietary needs were catered for. This included people on special diet due to their individual religious and cultural needs. People where appropriate were supported by staff to help prepare and cook their meals and make drinks when required to promote and maintain their life skills. People were assisted and encouraged in a kind, patient, and respectful manner. We observed that snacks and drinks were available to people throughout the day to promote people's hydration and nutritional needs.

Prior to this inspection the CQC received concerns that people were not always given a choice of food and were made to eat only what was on offer. During our visit people, who were able to tell us and their relatives had positive opinions about the quality and choice of the food provided. One person when asked if they liked the food gave a 'thumbs up' sign and replied, "Yes." Another person confirmed to us that they could, "Eat what I want." A relative confirmed to us that, "I have no concerns."

We spoke with staff about what choices people were given when it came to food. A senior support worker told us about how they worked alongside one person they supported. They said, "If staff cook [for named person] without his help he does not like to eat the food and will say, 'I don't want to eat it.' Staff would then ask him what he would like to eat and an alternative choice is given. [Named person] has never been told that if he does not eat it there is nothing else. No, we try and encourage a balanced diet and give choices." This was confirmed during our observations. This showed us that people's individual nutritional and hydration needs were supported by staff.

The service worked with other external organisations to ensure that the best possible quality of service was provided. For example, working with representatives from the local authority commissioning team and the quality improvement team so that the overall quality of the service was monitored.

People were supported in a timely manner to attend external health care appointments, when required. Visits included; GP visits; dieticians and paediatric physiotherapists. However, we noted in one person's care and support plan that the advice given by the paediatric physiotherapist was not reflected in the person's care records as guidance for staff. This meant that there was an increased risk that staff may not follow this guidance.

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.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty under the court of protection were being met. The registered manager told us and records showed that one court of protection application was in progress, however, we saw that it had not yet been authorised.

Staff had received training in MCA and were able to demonstrate an adequate understanding to us. A senior support worker said, "Don't assume that a person does not have [mental] capacity. Try to involve them in everything we do and give people choices." This showed that people would not have their freedom restricted in an unlawful manner.

## Is the service caring?

### Our findings

People using the service and their relatives had positive opinions about the care and support provided by staff. This was confirmed by our observations during the visit. One person said, "Yes, I am happy here...staff are kind, always nice." Another person smiled and gave us a 'thumbs up' sign and a smile when asked if staff were kind to them. A relative said, "[Family member] has lived there 10 years and is definitely happy and happy when we visit her." Another relative told us, "I feel staff look after him well...I am very happy with the care [he receives] Positive Steps, I think they are brilliant. They communicate well and [family member] is happy there. Staff know him very well."

Staff knew and respected the people they were caring for. Staff were able to demonstrate to us that they knew people's preferences, personal histories and wishes. This knowledge included the promotion, by staff, of people's independence. Records documented what people were able to do for themselves and what staff were to assist with. This was to help staff maintain and promote people's life skills. Staff knowledge also included distraction techniques known to work for people who were at risk of becoming anxious. A staff member explained to us, "When a person's behaviour becomes challenging we try to talk them down and redirect them. Usually this is quite effective. You try to respond quickly so that the [situation] does not escalate." This showed us that staff supported people in a reassuring and caring way to help reduce the fears for the person who was becoming agitated.

Our observations showed that staff respected people's choices and asked permission before supporting them. Throughout both visits we saw that staff asked people what they would like to do and how they would like to be supported. Staff responded to people's choice and when a person was unable to verbalise their response, we saw that staff paid attention to people's body language and facial expressions as a form of interaction. This showed us that people's choices were sought and respected by the staff members who were assisting them.

Advocacy information was available on request for people if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Relatives told us that they were involved in the setting up, review and agreement of their family members care and support plans. This was alongside their family member and their assigned social worker. Relatives had positive comments about staff, and said that communication was good. Records showed that meetings to review people's care and support needs were held for people living at the service to express their views and, where possible, be involved in decisions. One relative told us, "The [staff] has been flexible due to my lack of mobility and held meetings and reviews [of family members care needs] at my home, [so I can attend]." Another relative said, "[Family member] has transitioned successfully into adult services because of Positive Steps [staff]. I am involved in all care decisions re [family member]. She has quite challenging behaviour and staff work and communicate with her. They have dealt with her behaviour and it would be how we would deal with it." This they said was because the staff had got to know their family member and their individual needs very well. They went on to say, "Staff have been at [Positive Steps] a long time, I think

that says a lot."

Positive comments were given by relatives when asked if staff promoted and maintained their relative's privacy and dignity. One relative said, "[Staff] maintain [family members] dignity, they keep her well dressed and her hair clean and tidy. It is female staff all of the time that support [family member] with their personal care." The relative went on to tell us that this was their preference. Our observations showed that staff knocked on people's bedrooms and announced themselves before entering. This showed us that staff respected people's privacy.

Visitors were encouraged and made welcome at the service. Staff also supported people's right to family life, by supporting them to visit relatives in their own homes. A relative said, "Staff support [family member] to visit me overnight." Another relative told us, "We visit the [service] every week and are made welcome."

## Is the service responsive?

### Our findings

Care and support plans documented people's daily living needs, support and care needs and health requirements that had been assessed prior to them moving into the service. This assessment was in place to make sure that staff could meet the person's individual requirements, prior to them moving in. From this information care and support plans and risk assessments were developed in conjunction with the person and/or their relative or legal representative or advocate. These documents acted as prompts for staff on how each person wished to be supported, including their individual likes and dislikes, preferred routines, interests and personal preferences. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current requirements. Relatives of people using the service told us of the communication they had with staff about their wishes and how these were respected where possible. One relative told us, "Nothing is too much trouble."

Prior to this inspection the CQC received concerns that people were stopped from taking part in activities by staff when their behaviour had challenged themselves or others. A senior staff member explained to us that people's activities in the community were only delayed if the person's behaviour and agitation could cause themselves or others harm.

During our visit we saw individual activities taking place. Staff supported people out and about in the local community, to promote and maintain their social inclusion and within the service. One relative told us how staff encouraged their family member to take part in activities. They said, "Staff motivate [family member] to walk and do activities. As such they are much fitter." Another relative told us, "Staff support [family member] to go riding, walking, shopping...he always tells me what activities he has done." A person using sign language told us that they had gone walking and swimming, which they enjoyed. Another person described to us how they liked to spend their time when not attending school. They said they, "Use the [computer tablet], watch lots of TV programmes and go out when I want. I go to school and I really enjoy this." They went on to tell us how there were always two staff with them in response to their needs and that within the service, there were, "Always staff here."

To make sure that more people were able to access information about the service, we observed that notices and some information was available in large print, pictorial or easy read formats. This enabled people feel more involved with the service and have information more accessible to them.

We saw that the service received compliments from relatives of people who had used the service. Compliments were used to identify to staff what worked well. One compliment read, "A big thank you, you have all worked so hard." Another said, "Thank you for all that you do for my beautiful boy: you are all brilliant." However, although the complaints policy was discussed with people during meetings with staff, we noted that the provider's complaints policy was not in an easy read or pictorial format. This meant that there was an increased risk that not all people using the service would understand the information. The registered manager told us that they would implement the complaints policy into an easy read and pictorial format so that more people could access and understand it going forward.



Relatives of people using the service told us that they knew how to make a complaint. They said that any suggestions or concerns raised with staff were listened to and dealt with. One relative told us, "Concerns raised with staff are dealt with immediately." Records showed that the service had received complaints since the last comprehensive inspection. We saw that these complaints had been investigated and any action taken to try to reduce the risk of recurrence fed back to the complainant.

## Is the service well-led?

### Our findings

Staff told us that learning and actions taken from incidents to reduce the risk of recurrence and improve the quality of the care provided were discussed during staff handovers and at meetings held. However, there was a lack of documented evidence of any actions taken as a result of learning from these events. This meant that there was an increased risk that any patterns that may emerge from a review of these records of actions may be overlooked, and as such the improvement was not always sustained.

Monitoring audits of the service provided were carried out by the registered manager and then signed off by the director of the service. Areas for improvement were noted and either actioned or on-going. However, we found that areas noted as requiring improvement found during this inspection had not been identified during these audits. This included new staff recruitment checks and people's care and support plans and risk assessments having all the necessary key information in them as guidance for staff. This demonstrated to us that the quality monitoring of the service was not always as robust and thorough as it could have been.

During our visit we found minor errors in people's financial records that had not been found during recent audits of the records. We also noted that the staff members who audited people's individual financial records were also the same staff who made entries onto these records. This meant that there was an increased risk of a conflict of interest. We spoke with the registered manager about these issues during our visit. They said that they would look at making the necessary improvements.

The registered manager told us how they made unannounced visits to each of the supported living services during the day time and sometimes in the evening. They said these walk arounds was to ascertain how the service was being run during these times. However, these quality monitoring checks were not documented and if there were any improvements found as requiring an action these were also not documented. This meant that that not all quality monitoring checks carried out were documented as part of the providers evidence of a robust governance process in place.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (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. The registered manager was supported on a day-to-day basis by support workers.

Observations showed that the rating from the last CQC inspection that was carried out on 16 May 2016 was displayed on a communal notice board for people, their visitors and staff to refer to. Records showed that the CQC was informed of the majority of incidents that the provider was legally obliged to notify them of. However, a missing safeguarding notification showed us that the registered manager was not always aware of their responsibilities in reporting notifiable events to the CQC when required.

Staff told us that there was a clear expectation, by the registered manager, for them to deliver good quality

care and support. Staff told us that communication was good between the registered manager and themselves. A senior support worker said, "Staff are asked their views on how the service is run by the [registered] manager. The [registered] manager is good at asking staff for their opinions...if you don't talk to the [registered] manager about problems, she won't be able to help you."

Meetings were held with people using the service for them to discuss and feedback their views on the service provided. Responses showed that the feedback was positive. We also noted that surveys were sent out to relatives so they could engage with the service and feedback their views. One relative said, "I am able to give feedback on the service...a survey has been sent out recently." This showed us that people and their relatives were encouraged to engage with the service and given the opportunity to feedback their views.

During the inspection the registered manager told us that they were not aware of the CQC guidance of 'Registering the Right Support.' This is the CQC policy on the registration and variations to registration for providers supporting people with a learning disability. The registered manager also confirmed that they were not currently signed up for 'The Driving Quality Code.' This code was developed following the Winterbourne review that identified abuse of people with learning disabilities at Winterbourne View. The government and many other organisations that support people with learning disabilities are taking action to make sure that this never happens again. The registered manager confirmed to us that they would read these guidance's and familiarise themselves with them and their key principles.

Staff worked in partnership with key organisations to provide joined-up care. The registered manager told us how they were working alongside external organisations to help support a person currently living at the service transition into the setting up of their own home. They also talked us through how they had helped younger adults, alongside other organisations transition from children's services into adult services. This demonstrated to us that joined-up working took place with other external organisations.