Southdown Housing Association Limited

Southdown Housing Association - 52 Mill Lane

Inspection report

52 Mill Lane
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East Sussex
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Date of inspection visit:
15 June 2016

Date of publication:
26 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Southdown Housing Association - 52 Mill Lane provides accommodation and personal care for up to five people with a learning disability and complex needs. The young adults require support with personal care, mobility, health, behavioural and communication needs. There were five people living at the service at the time of our inspection. Accommodation for people is arranged on the ground floor, with a sleep-in room for staff on the first floor. The home was adapted to meet the needs of people living there. Each person had their own adapted bedroom.

Southdown Housing Association - 52 Mill Lane is a detached house in Portslade, close to Brighton. The service is one of six residential care homes run by Southdown Housing Association Limited, a not-for-profit specialist provider of care, support and housing services in Sussex.

The service had a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the home is run.

Medicines were not managed safely and in accordance with current regulations and guidance. Systems in place had not ensured that medicines were recorded and stored appropriately. We have identified the issue as an area of practice that needs improvement.

The registered manager and staff had received training and were knowledgeable about of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, mental capacity assessments were not always completed in line with legal requirements. Mental capacity assessments were needed for people who may not be able to consent to, for example, bed rails. We have identified these issues as an area of practice that needs improvement.

People appeared happy and relaxed with staff. Relatives told us they considered their loves ones were safe. A relative told us, "If we saw [our relative] unhappy we would not hesitate to talk to [the registered manager] but it's never happened. We chose Mill Lane and we know it's a lovely place."

There were sufficient staff to support people. The registered manager said, "We have just amended staffing levels based on the needs of one of the clients. We used to have sleeping night staff, but due to the complex night time care needs of one of the clients, we agreed we needed waking night staff."

Staff were knowledgeable and trained in safeguarding and what action they should take if they suspected abuse was taking place

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Staff took time to talk with people and followed practice that was caring and supported the value of dignity. We saw support provided by staff that staff that was kind and compassionate. We were told the following, "The care of [my relative] is very good. Staff are fantastic and adore my daughter. [Named keyworker] genuinely seems fond of all the residents. I've heard them sing and provide touch, which is so important, they have taken the time to really build up a bond with residents."

People had access to appropriate healthcare professionals. Staff worked in cooperation with other health and social care professionals to ensure that people received appropriate care and support. Staff told us how they had regular contact with the GP if they had concerns about people's health.

Some people needed specialist support with complex healthcare needs, including PEG feeding. This was required when people could not maintain adequate nutrition with oral intake. Nutritional assessments were in place that identified what food and drink people needed to keep them well and what they liked to eat.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service. Arrangements for the supervision of staff were in place. Staff told us they felt supported. A staff member said, "I get regular supervision and I had a really good induction."

Systems were in place to monitor the quality of the service provided and regular checks were undertaken on all aspects of running the service. The registered manager had a range of tools that supported them to ensure the quality of the service being provided.

People's relatives and staff told us it was well-run and organised service. The service was small enough that the registered manager knew each person and staff member well. Staff and family members were positive and spoke highly of the registered manager and their leadership, they described the management style of the service as open. A relative said, "The manager is very approachable and I feel communication is very good here."

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

Southdown Housing Association - 52 Mill Lane was not consistently safe.

Medicines were not recorded, managed and stored appropriately.

Staff received training in how to safeguard people and were clear about how to respond to allegations of abuse.

There were enough suitably qualified and experienced staff to meet people's needs.

Staff recruitment practices were safe.

Is the service effective?

Requires Improvement

Southdown Housing Association - 52 Mill Lane was not consistently effective.

Documentation did not record if least restrictive options or issues of consent were considered.

Staff received training that was appropriate to their role and responsibilities.

Staff had a good understanding of people's complex support and health needs.

Is the service caring?

Good

Southdown Housing Association - 52 Mill Lane was caring.

People's relatives were positive about the care their loved ones received. This was supported by our observations.

Support was focused on people's preferences where it could be established and respect of their dignity.

Staff were kind, thoughtful and gave compassionate care to the people they supported.

Is the service responsive?

Good

Southdown Housing Association - 52 Mill Lane was responsive.

Records of care gave clear information to guide staff on the support people needed and included people's choices and preferences.

People had access to a wide range of meaningful activities which were tailored to individual needs.

Systems were in place for receiving, handling and dealing with complaints.

Is the service well-led?

Good

Southdown Housing Association - 52 Mill Lane was well-led.

Relatives and staff expressed confidence in the management of the service.

They commented that the management was approachable and listened to their views.

Systems were in place to assess and monitor the quality of the service and the day-to-day running of the service.

Southdown Housing Association - 52 Mill Lane

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 checked 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 took place on 15 June 2016 and was unannounced. It was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about.

During the inspection we spent time with people who lived at the service. We spent time in the lounge, kitchen, and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted. People were unable to use structured language to communicate verbally with us, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with those that knew people well. We gained the views of staff and spoke with the registered manager and three support workers.

We contacted selected stakeholders, including four health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. Those that responded were happy for us to quote them in our report.

We looked at three care plans and three staff files and staff training records. We looked at records that

related to how the service was managed that included quality monitoring documentation, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 4 January 2014 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Peoples relatives said they felt their loved ones were safe and staff made them comfortable. One relative said, "If we saw [our relative] unhappy we would not hesitate to talk to [the registered manager] but it's never happened. We chose Mill Lane and we know it's a lovely place." Staff we spoke with said that they had no concerns around safety. However, despite the positive feedback we received, we identified an area of practice that needs improvement.

We looked at the management of medicines. Medicines were not stored safely in line with requirements. We saw that one medicine was not labelled with the pharmacy label showing the patient name, medicine name and strength and dose instructions. The medicine cabinet did not have the temperature recorded. The registered manager was unable to provide an assurance that medicines were stored correctly. For most services this may mean temperature monitoring but there was no way of establishing that the medicine was safely stored. One medicine was stored in a separate medicine fridge; checks were not made to establish that it was stored within the recommended temperature range for it. This presented a risk that medicine stored at an incorrect temperature may become desensitised and potentially ineffective. We brought this to the attention of the registered manager who gave an undertaking this issue would be addressed. The provider subsequently told us that they had considered temperature in relation to the storage of medicine and that as the cabinet was neither in direct sunlight nor near a radiator was not considered at high risk of fluctuations in temperature. However, we have identified the above as an area of practice that needs improvement.

We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. Staff were trained in the administration of medicines. A member of staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines. We observed a member of staff administering a medicine sensitively and appropriately. We saw that they administered the medicine in a discreet and respectful way and stayed with them until they had taken them safely.

There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. A staff member said, "I would speak to [registered manager's name] and make a written report about everything".

Risks to individuals were identified and well managed. There were individual risk assessments in place which supported people to stay safe, while encouraging independence where it could be achieved. For example, an assessment evaluated the risk to a person who liked to move around on the floor. The person liked to spend time in their room and sometimes be away from other people. There were concerns for the person's safety at these times and a creative solution was found to hang a curtain across the door that the

person could navigate through when they chose. The curtain provided staff with the ability to safely and discreetly monitor their wellbeing. Other risk assessments were completed that were specific to people's needs, such as mobility, nutrition and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We spoke with staff and the registered manager about the need to balance risks. One staff member told us, "Our training has encouraged us to take a person centred approach. So we always consider our responsibilities as learning disability support workers. I hope that I promote choices and decision making against positive risk taking. I am mindful of my duty of care and adopting safe practice and safeguarding."

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Health and safety checks were undertaken to ensure safe management of, for example, electrics, food hygiene, hazardous substances, items of moving and handling equipment and staff safety. Regular fire alarm checks had been recorded, and staff told us they knew what action to take in the event of a fire. Plans were in place to instruct staff on the actions required during or immediately following an emergency or incident that threatened to disrupt normal activities. We were told by staff that there were systems in place to evacuate people and deal with emergencies.

Staff were always available to provide care and support. Our own observations supported that there were enough staff. One member of staff commented, "Staffing levels have been an issue. I believe we are employing more staff. There is a new senior [support worker] in post and things are improving, however we would always benefit from more relief staff." Staffing levels were reassessed when the needs of people changed, to ensure people's safety. The registered manager told us, "We have just amended staffing levels based on the needs of one of the clients. We used to have sleeping night staff, but due to the complex night time care needs of one of the clients, we agreed we needed waking night staff. The client suffers with epilepsy and although they have a pulse guard in place which connects to an iPad and alert us if their pulse goes high, we didn't want to just rely on technology."

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the service. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS is a national agency that keeps records of criminal convictions. They requested and checked the references provided for staff and their suitability to work with people.

Requires Improvement

Is the service effective?

Our findings

People's relatives told us they believed people received effective care and their individual needs were met. We heard they thought the staff had the rights skills and experience to meet people's complex needs. One relative said, "Staff bend over backwards to meet [my relatives] needs." Another relative said, "[Named relative] can't talk or communicate in the way you and I are now but staff are good at interpreting the sounds and indications he gives, like turning his head in a particular direction or eye pointing." However, despite the positive feedback we received, we identified an area of practice that needs improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager understood the principles of DoLS and had made the relevant DoLS application so that all five people were subject to a DoLS authorisation. Training schedules confirmed staff had received training on the MCA. Staff had some knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the care they were to provide to a person before they gave it and sought to gain their consent. We saw this in practice. One member of staff told us, "If someone refuses support, we may try a different approach or try again later to see if they've changed their mind but we respect their decision."

However, mental capacity assessments were not always completed in line with legal requirements. In the case of one person, we looked to find their mental capacity assessments as their care plan stated they lacked capacity for personal care. The registered manager identified that mental capacity assessments hadn't been completed. Observations of support identified that people had bed rails in place. Within the MCA, where people's movement is restricted, this could be seen as restraint. Bed rails were implemented for people's safety but do restrict movement. Bed rails risk assessments were in place which considered the risk and how to meet it but failed to demonstrate whether the person had consented to the bed rails or not. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom, for example in the use of bed rails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. We discussed with the registered manager how the care plans advised that people lacked capacity but we identified that this needs to be underpinned with a mental capacity assessment and best interest decision to demonstrate why it is in the person's best interest, in this case for a bed rail to be used. The registered manager advised that they didn't supply the beds, but as staff engaged with the act of pulling the bed rails up, they need to demonstrate they are working within the principles of the Act and need a copy of that person's mental capacity assessment. The registered manager recognised that mental capacity assessments were needed for people who may not

be able to consent to bed rails. We brought this to the attention of the registered manager who gave an undertaking this issue
would be addressed. We have therefore identified this as an area of practice that needs improvement.

People were supported to have access to healthcare services and maintain good health. Each person had a health care plan which provided detailed information on people's individual health care history and requirements. These records identified a wide range of health care professionals, such as physiotherapists, who were engaged to support people to maintain good health. Referrals had been made to other health professionals when required. This included GP's and specialist community learning disability nurses. One staff member said, "All clients are weighed monthly, if [person] loses weight and drops to a certain level, we contact the dietician." Appointments were seen to be scheduled with health care professionals, such as the Speech and Language Therapist (SALT). Staff were proactive with regard to people's health care needs. One staff member told us, "We have good relationships with relatives and healthcare professionals.

Some people required total support in regard to their mobility. The premises and equipment was laid out appropriately to meet people's needs. People had specialist beds and mattresses to prevent the risk of skin pressure areas. There were tracking hoists in place to aid the transfer of people, for example from their bed to sitting chair or bath.

Details of each person's dietary needs were assessed and recorded. Some people needed specialist support with complex healthcare needs, including PEG feeding. This was required when people could not maintain adequate nutrition with oral intake. Nutritional assessments were in place that identified what food and drink people needed to keep them well and what they liked to eat. Staff were trained in gastrostomy care and enteral feeding for people who required that support. Staff told us about one person who enjoyed their food and were provided with choices about what they wanted to eat that they could manage and that did not overwhelm them. Adjustable stools were provided for staff so that they sat at peoples eye level when they supported people to eat.

People received care from staff that had knowledge and skills to support them. There was a full induction programme that included all essential training for staff. Training records confirmed that staff had completed the providers own induction programme, skills for care common induction standards or care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensured staff that were new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.The structured induction programme included an orientation during which staff were introduced to the policies and procedures of the provider. Staff spent time getting to know people and read their support files and risk assessments. Time was given to shadow other staff. The registered manager told us they worked to ensure new staff completed the provider's induction workbook witin the first 22 weeks of their employment.

All staff completed training that the provider considered mandatory. It included such areas as safeguarding, moving and handling, fire safety, basic first aid, food hygiene and infection control. It also included epilepsy awareness and a positive person centred approach to support. This explored strategies and methods to increase the person's quality of life, through teaching new skills and adapting the environment to promote achievement and change. This was vital for people who experienced difficulties in communicating and used behaviour and alternative communication techniques as a way to express themselves. The provider also ensured training was given that was relevant to meeting the needs of people living at the service, in areas such as enteral feeding and postural management. Staff told us the training they received enabled them to begin to understand people's complex health care needs. One member of staff said, "Southdown is very hot on training. I can phone the training department and enquire about any specific training I might want to do.

I would say Southdown's excels at training."

Staff received regular supervision and appraisals. Supervisions were documented and staff knew when they were due to take place. One member of staff said, "I get regular supervision and I had a really good induction." Staff told us they felt supported by the registered manager and communication was open. Staff felt supported and involved in the day to day running of the service. They told us any changes were discussed and information shared at meetings and handovers. Staff told us their feedback was listened to and suggestions were taken seriously, this made them feel involved and encouraged to continually improve the service.

Good

Is the service caring?

Our findings

People were consistently well cared for and this had a positive effect on their individual wellbeing. Staff focused on people's comfort, so that they received appropriate care and support. People's relative's praised the care and thoughtfulness of the staff. A comment included, "The care of [my relative] is very good. Staff are fantastic and adore my daughter. [Named keyworker] genuinely seem fond of all the residents, I've heard them sing and provide touch, which is so important, they have taken the time to really build up a bond with residents."

Staff were focused on people and their needs and gave everyone the same respect, kindness and compassion. Staff interacted well with people, they used speech, body language and, where it was appropriate, touch to engage with people. People responded to staff and they recognised the importance of supporting people to feel that they were valued. Dignity was promoted. A member of staff told us, "When providing personal care, we ensure doors are closed. When pushing the wheelchair, we explain where we are taking the person." One person's relative said, "Let me give an example of how they respect and look after people. Last year my relative was very ill and went into hospital. Staff went in every day to support him. He can't speak for himself, so staff were on hand to look out for him." Staff took time to talk with people, addressed them by their preferred name and followed practice that was caring and supported the value of dignity. For example, when we arrived at the service, the door was opened to us by the registered manager accompanied by a person in their wheelchair. The person was immediately introduced to us and they were consulted about whether we were to be admitted. The warmth, inclusiveness and integrity demonstrated in the exchange demonstrated the caring values seen throughout the inspection.

People were supported to be independent and make day-to-day decisions. We observed that staff strove to offer meaningful choices. Staff told us they were encouraged to consider how to maximise the choices available to people. One staff member told us, "With those who eat orally it can sometimes be quite difficult to know what people prefer but we give choices and offer a variety of food. For example, [named person] has his own Makaton and will make choices between two food choices that are offered. They struggle to make a choice if offered more than two options. So, at breakfast we will show him a bottle of tomato ketchup or Weetabix to help him choose between a cooked breakfast or cereal." Staff demonstrated a strong commitment to providing compassionate care. It was clear that they knew people well and had a good understanding of how best to support them. We spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what they liked to do, the activities they took part in and their preferences, for example, in respect of food. Staff knew about peoples' families and some of their interests. A member of staff said, "It's about getting to know people. [Three named people] find it difficult to make choices, but it's about growing to know them and their likes and dislikes."

People's bedrooms were spacious, in good decorative order and had been personalised for example with photographs, sensory items and art. This helped to create a familiar, safe space. People were comfortable in their home and they were supported to maintain their preferred personal and physical appearance.

People's likes and preferences were documented throughout their support plans. For example, even before meeting a person from reading their file we could identify the type of food they liked and their favourite activities when out and about. Plans were written from the perspective of the person receiving support. People had an allocated key worker who was knowledgeable about the person's likes and dislikes. A key worker is a person who co-ordinates all aspects of a person's support and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Key workers told us it was essential there was a bond and respect between the person and their key worker to ensure people received the best possible support. Keyworkers worked to plan how they were able to achieve more independence. A relative of a person said, "[My relative] resists many things as part of who they are. For example, they don't like going out in the car. The keyworker and all staff actually have gone out of their way to find things locally. For example, they keep up the swimming at the local swimming pool that's within walking distance."

People were able to maintain relationships with those who mattered to them. For example, we saw in diaries that there was a reminder for staff to buy Fathers' Day cards for relatives. Visiting was not restricted and guests were welcome at any time. Relatives told us they could visit at any time and they were always made to feel welcome. One said, "I can call in at any time and am always made to feel welcome. I have never seen anything other than an excellent quality of care."

Good

Is the service responsive?

Our findings

People's relatives told us that the service was responsive to people's needs. The registered manager and staff kept others well informed about any changes in the support people needed, for example, if someone became unwell. As well as being kept informed, those in the person's life also felt fully involved in the support provided. They told us they were updated with any changes or issues that affected care. We had the following feedback, "Communication is very good. I can talk with [registered manager] or any of the staff. They keep me informed about what [my relative] does and I can see he is a happy young man." People's support plans clearly identified their needs and reflected their individual preferences for all aspects of daily living

We looked at the support records of three people. The aims of the support plan included for the team to work consistently in their approach, to provide a safe environment and to work towards improving the quality of life for the individual. Support plans contained good, clear objectives to guide staff on how care and support was to be provided. In these, people's preferences, likes and dislikes were recorded. For example, a plan included, 'Points to remember and the approach needed – [named person] has a good sense of humour and is often fun to be with. [Person] can tease members of staff by asking for things he doesn't want, but it's easy to tell when he is teasing by his smile and his laughter.'

The history of each person made up an important part of each person's support plan. The information painted a portrait of the person and the service made use of the details to record the support they provided for that individual. The information was used as an aid to help staff to get to know the person they were caring for even better, so that support effectively met their needs. For example, one person's diagnosis included bi-polar disorder and cerebral palsy. It identified how the disabilities affected how much they could do for themselves, which led to expressions of frustration. Another person was shown wearing a football scarf in an old photograph. Staff used this as a prompt to support them to go to a football game at the local stadium.

People were engaged in activities that were meaningful to them. Considerable thought and energy created an environment that provided stimulation and interaction. Throughout the service sensory items were used to induce feelings of calm or prompt stimulation, depending on what suited the individual need at the time. People were supported to engage with activities that promoted their well-being and identity. During the day we were there, a person went out to town and another went swimming. A member of staff said, "We encourage them to do as much for themselves as possible. They access hydro, music groups. We go to cafes and go on various trips." Activities were reviewed and feedback was sought to see what activities had been successful. One person's timetable of activities included; local café/trips, aromatherapy, cook dinner, hydrotherapy and gardening. The service celebrated people's birthdays and special events throughout the year.People had the opportunity to record and share these events and what they were doing, for example through pictures taken to share with family and friends.

One-to-one meetings and client meetings were held to bring together and seek people's views and share information. Significant challenges were faced in gaining and advocating for people and meetings were

used as a space to creatively engage with people with complex needs. For example, time was taken to use, pictorial prompts and the sense of touch to engage with each person and acknowledge their contribution. Feedback from relatives and stakeholders was sought and seen to be positive. The information that was captured was collated by the provider and results shared with the service.

There was a staff handover between shifts. These provided staff with a clear summary of what had happened during the course of the day and gave them the opportunity to plan for the day ahead. For example, staff used it to allocate duties and discussed individual updates on people. Staff used the time productively to ask each other questions and share ideas and views.

A complaints procedure was in place and displayed. Relatives and staff told us they felt confident in raising concerns. The following response was typical, "If I had a concern I know I could talk to [the registered manager]. If I saw my child unhappy I could talk to the manager and they would look at it. But I've never had to." The service had not received any complaints in the previous twelve months. However, documentation existed for any that were received to be followed up and feedback to be given to the complainant.

Good

Is the service well-led?

Our findings

Everyone we spoke with shared the same determination to provide quality support to people. It was important to the registered manager and staff that this was done while maintaining a relaxed homely atmosphere. The service was small enough that the registered manager knew each person and staff member well. Staff and family members were positive and spoke highly of the registered manager and their leadership; they described the management of the service as open. A relative said, "The manager is very approachable and I feel communication is very good here." Staff members spoke positively about working for the provider and commented they enjoyed working in a service where the ethos was on the delivery of person centred support. A member of the team commented, "Staff morale is good. I think we have good team work and the manager is approachable."

The culture and values of the provider were embedded into every day practice. Staff we spoke with could tell us about the vision of the service. From our observations of staff interactions with people it was clear the values were embedded into practice as support was person centred. Staff spoke positively of how they all worked together as a team. They said they supported and helped each other. The registered manager reflected on his staff team and what it meant for the people they supported, they said, "I'm lucky with the staff group I have. I can leave here of a day and be confident that the team that remain are working hard to achieve outcomes for people."

The registered manager told us their core values included having an open and transparent approach. They supported people's relatives and staff to share their thoughts, concerns and ideas with them in order to enhance the service. We spoke with staff about how information was shared. They told us they were given updates through daily staff handovers and team meetings that were held every two weeks. Handovers considered the physical, social and emotional presentation of each person. Where there were concerns, for example, if a person had seen a health professional either as part of a regular assessment or in response to a health issue, their needs were discussed. Team meetings provided an opportunity for staff to raise and discuss issues and for staff to remind colleagues about key operational updates. Staff were positive about the meetings as they provided an opportunity to share ideas and provide updates on individual people and pointed to any changes that had happened. Staff thought their suggestions to improve support were acknowledged and in this way, felt listened to. For example, a Quality Day, held a month before our visit, was attended by all staff. In it, staff looked at what people did during the day and questioned whether it met their needs. As a result, it was felt that power packs for some people's wheelchairs would further increase their independence and scope for activity. We saw that the keyworkers had contacted wheelchair services for an assessment and were awaiting an outcome.

The registered manager was visible and active in the service. We saw that they worked hands on shifts and some weekends and that they were always available to work with people when required. Senior managers were frequent visitors to the service. For example, we saw that the operations manager was a monthly visitor. As well as meeting with people and staff they observed practice and sampled records and systems to assess the overall quality of a service. An action plan was completed for any issues that were identified as arising from visits. A member of staff said, "Every month the operational manager attends. I would say I feel

listened too and valued." The registered manager attended regular managers meetings with others from within Southdown Housing Association. They told us the meetings provided an opportunity to share and learn from their peers.

There was an open learning culture within the service. The registered manager welcomed input from other professionals. They recognised the skills and experience of health and social care professionals to support them and the service. They drew on resources from within the provider's organisation, for example, the behaviour support team to improve interaction with people but also external sources such as pharmacists, dieticians and speech and language therapists.

The registered manager had a range of tools that supported them to ensure the quality of the service being provided. They undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety and medication. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the support delivered. For example, we saw that in light of one internal audit, repairs were made to areas of the service.

The registered manager explained how they met their CQC registration requirements. They explained the process for submitting statutory notifications to the CQC to ensure that they were sent in a timely manner. This meant we had the most up to date information. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager was able to describe unintentional and unexpected scenarios that may lead to a person experiencing harm and was confident about the steps to be taken, including producing a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.