St Cuthberts Care

St Cuthberts Care Supported Living

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 6, 7 and 12 October 2015 and was announced. We had last inspected St Cuthberts Care Supported Living in September 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

St Cuthberts Care Supported Living provides personal care and support to people with learning disabilities. At the time of our inspection services were provided to 27 people who lived in shared houses with support.

The service had a manager in post who was applying to become the registered manager. A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people using the service were safely cared for and risks to their well-being were appropriately managed. Robust procedures were followed for safeguarding people against the risk of abuse and handling personal finances. The service promoted people's understanding of their rights and staff had a good awareness of their responsibilities in protecting people from harm.

New staff were thoroughly checked and vetted to ensure they were suitable to be employed. Each person had a dedicated staff team that enabled them to receive consistent care and support. Staff were given training relevant to the needs of the people they cared for and were supervised in their roles.

Suitable arrangements had been made to make sure people received their medicines safely. Staff provided people with support in meeting their health care and nutritional needs to maintain their welfare.

People were consulted and made choices about the ways their care and support was provided. Where people were unable to make important decisions, the service upheld their rights under mental capacity law.

People were happy with their care and had formed good relationships with the staff. Relatives felt that the staff were caring, treated people with respect and helped them to develop independent living skills. The service encouraged people to express their views and be fully involved in their care planning.

Detailed support plans were in place which reflected the person-centred care which people received. People led active lives, engaging in activities they enjoyed and taking part in their community. There were clear systems to seek feedback from people and take action on any complaints about the service.

The service had an open culture and management and staff worked inclusively with people, their families and other professionals. The manager was supportive and provided good leadership and direction to the staff team. The management were pro-active in ensuring that standards were regularly monitored and were committed to developing the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Appropriate steps were taken to safeguard people using the service from harm and abuse.

Risks were identified and acted on to ensure people's personal safety was protected.

There were sufficient numbers of staff to safely support people and meet their needs.

People were given suitable support in taking their prescribed medicines.

Good

Is the service effective?
The service was effective.

Staff were trained and supported to carry out their roles and care for people effectively.

The service upheld people's rights under the Mental Capacity Act 2005.

Staff supported people in staying healthy, to access health care services, and, where needed, in meeting their dietary needs.

Good

Is the service caring?
The service was caring.

There were positive relationships and communication between the staff, people using the service and their families.

Staff were caring and respected people's privacy and dignity. They worked in an inclusive way and supported people to be as independent as possible.

People and their families were involved in making decisions about the care and support provided.

Good

Is the service responsive?
The service was responsive.

A person centred approach was taken in the planning and delivery of care. Support was arranged flexibly and aimed at helping people to achieve their desired outcomes.

People were well supported to meet their social needs and be involved in their community.

A complaints procedure was in place and any concerns received were properly acted on and investigated.

Good

Is the service well-led?
The service was well-led.

A manager was in post who was applying for registration.

The management team promoted an open and transparent culture for people to influence the running of the service.

Good

Summary of findings

There were systems to assure and improve the quality of the service that people received.

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

The inspection was announced and took place on 6, 7 and 12 October 2015. We gave 48 hours notice that we would be coming as we needed to be sure that someone would be in at the office. The inspection was carried out by an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We gathered information during the inspection using different methods. We visited and met with four people who used the service in their homes and talked with two senior workers and a support worker. We spoke with three people and five relatives by telephone and contacted two commissioners of the service. During our visit to the office we talked with the manager, the operations manager and the director of care services. We looked at eight people's care records, seven people's medicine records, three staff files, staff training records and reviewed other records related to the management of the service.

Good

Is the service safe?

Our findings

People using the service expressed no concerns about their safety and relatives told us they felt their family members were cared for safely. Their comments included, "It's really good here, there's a happy atmosphere and the staff are all nice"; "(Name) tells me if the staff have changed and they would tell me if they were being mistreated"; and, "I'm quite happy with where my relative is. They're totally safe." One relative described an agreement they had with staff to telephone one another when their family member was travelling to and from visiting them. The relative also said that staff had helped organise their family member's bedroom to make it more spacious and keep it free from potential hazards. Another relative told us, "The staff encourage routines, like (name) always taking their key. It's their home and they feel safe there. I am more than satisfied."

A range of methods were used to promote people's understanding of their personal safety and their rights to be protected from abuse. Safeguarding was discussed at tenants' meetings and in educational meetings which had been trialled with other agencies such as the police and social services. The manager was currently working on producing pictorial workbooks to explain safeguarding in ways that people could understand. The manager had arranged tenants' forums where people had looked at rules, boundaries, complaints and plans to set out care in picture form with emoticons to help people in communicating their feelings. Safeguarding and complaints were also routinely discussed at monthly keyworker meetings to raise people's awareness and check if they had any concerns.

All staff were trained in safeguarding and had access to the service's safeguarding and whistle-blowing procedures. New staff were given a handbook with copies of the procedures and each supported house had a policies file for staff to refer to. The manager and senior workers checked that staff understood safeguarding during supervisions and ensured they were aware of what constituted abuse and the reporting process. The staff we talked with confirmed they understood their roles in preventing people from being harmed and knew how to report safeguarding incidents or poor practice.

A policy on the provider's statutory responsibility of 'duty of candour' had been introduced and discussed with staff at a team meeting. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

The manager had a good understanding of their safeguarding responsibilities and referred to the local safeguarding authority's thresholds for reporting concerns. In the past year one safeguarding incident had been reported to the local authority and notified to the Care Quality Commission. This had related to a person's actions impacting on the people they lived with and the service had taken appropriate steps to keep people safe.

We reviewed the safekeeping of people's personal money. Assessments were carried out to determine whether people were able to manage their finances independently or required support. Support plans were in place which clearly described the level of support that staff would provide. Most people had money held for personal spending in locked facilities in their homes and staff kept records of all expenditure. This was confirmed during a home visit where we saw clear cash records were maintained. A process was followed to authorise higher value spending, such as for holidays. Some people had arrangements under the court of protection or an appointee to support them in managing their finances. Staff did daily checks of each person's money, records and receipts and monthly checks of predicted spending against bank statements, which were signed off by the manager. An annual financial audit was also carried out to give people assurance that their money was being handled safely.

The manager told us there were three vacancies for support workers and interviews were being held in the near furture. We checked recruitment records for the last staff employed and saw all necessary checks had been carried out. Application forms and health assessments were completed and proof of identity was obtained. At least two references were sought, including one from the last employer, and references were scrutinised and verified. Disclosure and Barring Service checks were carried out and the service had a protocol in the event of employing anyone with a criminal record. Detailed interviews and assessments were recorded and applicants were given a literacy test. All recruitment was authorised by the director of care services to confirm that new staff had been properly checked and vetted and were suitable to be employed.

Good

Is the service safe?

Each supported house had a dedicated senior worker and a small team of support workers. Most of the people using the service were provided with 24 hour care and support, with sleep-in staff during the night. Senior workers organised the rosters to fit in with people's needs and activities and these were approved by the manager. The rosters were set out into individual and shared time to make sure people received the hours of staff support they were entitled to in line with their contracted funding.

A person using the service told us, "It's good to know there's someone (staff) here at night." A relative said their family member lived in a shared house that did not have staff overnight but that, if needed, they could get help from the staff who worked in the adjoining house. They said the house was in a central location, "In a safe and decent area", and that, "The staff have very much got a handle on things."

The service did not use external agency staff and existing staff or relief workers covered absence to ensure people had continuity of care. An on-call system was operated for staff to get advice and support from senior workers or the manager at any time, and if needed, to escalate emergencies to senior management.

The manager told us staff were expected to adhere to safe working practices and involve people, as far as possible, in maintaining a secure home environment. For example, staff followed procedures for fire safety, infection control and hygiene standards and carried out various safety checks. Personal emergency plans were in place in the event of people needing to be evacuated from their homes.

The provider had a risk team, consisting of the director of care and senior managers, and designated leads for safeguarding and health and safety who supported the service. The manager and senior workers were trained in assessing risks and had completed profiles for people which established the probability of risks and considered the consequences of harm occurring. Risks were identified according to the individual's needs and vulnerabilities and measures were taken to ensure that care was given safely. For example, one person's records showed that measures were taken to address risks associated with their health, nutrition, mobility, risk of falling, and skin integrity. Any significant risks affecting the organisation or people using the service were reported to the risk team and held on a risk register. The team kept an overview of the register and determined the necessary actions to mitigate the risks.

Staff who led shifts were responsible for reporting any accidents or incidents that happened. These were logged on a database and were recorded and could be analysed by type. They included accidents which had or had not resulted in injury, medicines errors, and 'near misses'. The manager reviewed all reports and documented follow up action before passing on the information to the risk team for analysis.

All staff were given safe handling of medicines training and had their competency assessed annually. We saw a thorough assessment had been carried out for a new support worker that ensured they had the necessary skills before they started to handle people's medicines. People using the service were assisted to varying degrees with their medicines, including staff taking responsibility for ordering, collecting, and administering. Wherever possible, people were encouraged to manage their own medicines and staff assessed and reviewed the risks involved. The service had responded appropriately to medicines errors by providing further training for staff and reviewing the risks around a person self-managing their medicines.

One person we talked with said they took medicines after each meal which staff gave them and recorded. Another person told us they were prescribed a medicine that they took themselves each evening. We saw people who were supported with their medicines had profiles with details about each medicine prescribed, the dosage, timing and potential side effects. Detailed medicine support plans were recorded which described the individual's requirements and routines and guided staff on the level of support needed. Medicine administration records (MARs) had clear directions and had been signed by staff to confirm they had given people their medicines at the correct times. However, during a home visit we highlighted two discrepancies in the MARs for staff to follow up. Senior workers audited medicines on a weekly basis and there was an annual audit of medicines arrangements to assure people their medicines were safely managed.

Good

Is the service effective?

Our findings

People using the service and their relatives told us they felt the staff were capable and provided effective care and support. Their comments included, "I like (name of support worker) and have known them a long time. I like them to go with me to the cinema and pub"; "The staff are really nice here, they always look after us"; and, "I've been very pleased and satisfied. They do an excellent job." No-one we spoke with raised any issues about the staff's skills or felt that they needed additional training.

New staff worked a 12 week probationary period and completed the Care Certificate. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. The manager showed us evidence of observations they had recently carried out with a new support worker who was undertaking this training. New staff also had an internal induction where they were introduced to people and given time to shadow experienced staff and read people's care plans to prepare them for their roles. A senior worker confirmed that they mentored and worked with new support workers until they were confident to work unsupervised.

We saw that all staff, including relief workers, completed mandatory training in safe working practices, such as safeguarding and moving and handling, at one to three year intervals. The provider had a training administrator who kept checks on when training was due and arranged courses on a rolling programme. Records showed that staff had undertaken other training relating to the needs of people who used the service. This included topics such as epilepsy, dementia, diabetes, downs syndrome and dementia, and dysphagia (swallowing difficulties). Staff undertook equality and diversity training that included championing people's rights. The manager told us they aimed to link all training to caring for people as individuals with diverse needs.

The service placed an emphasis on staff of all grades being given opportunities to gain nationally recognised care qualifications. All senior workers and most of the support workers had achieved National Vocational Qualifications in care, which have been replaced by Diplomas in health and social care. The remaining support workers were either studying or had been enrolled to undertake these qualifications.

The manager took responsibility for supervising any staff who were failing to meet the provider's standards of care. A delegated system was in place to provide all staff with individual supervision every eight weeks. These sessions were scheduled and we saw that supervisions were carried out at the stated frequency. Records of supervision demonstrated that there was meaningful discussion around the staff member's strengths, practice, attitude and any training needs. All staff were also given a detailed annual appraisal to review their performance.

The staff we talked with confirmed they were suitably supported in their roles. A support worker told us, "We get excellent training and are given plenty of notice for when refreshers are due. I also get regular supervision."

We found that wherever possible people were able to direct how their care and support was given. For example, people gave permission for their personal information to be shared and for staff to use broadband to access and maintain their care records. Consent was sought for specific areas of support such as administering medicines and checking bank statements to reconcile personal spending. We saw assessments were carried out of people's rights and freedoms and ability to make decisions and give consent to their care plans. People had agreed to their care and risk management plans and had monthly meetings with key workers to evaluate the effectiveness of their support.

The manager and senior staff were trained in the implications of the Mental Capacity Act 2005. We were shown that assessments of mental capacity had been completed in conjunction with people's representatives and other professionals involved in their care. In some instances these had led to decisions being made in people's best interests. For example, for staff to provide support with managing personal finances and for a person to access the community without support. The operations manager told us that formal decisions were kept under review and recent re-assessments had resulted in two people having restrictions removed and/or reduced. We were told that at present no-one using the service was subject to court of protection arrangements for decisions around their health and welfare.

The manager said that none of the people using the service currently presented with significantly distressed or challenging behaviours which could be harmful to themselves or others. They told us excessive control or restraint was never used and, when needed, referrals were

Good

Is the service effective?

made to a specialist challenging behaviour team for support. This was confirmed in support plans which set out clear guidance for staff on taking consistent approaches. The staff we talked with were aware of triggers to behaviour and recognised, for instance, the importance of limiting changes to a person's usual daily routine. All staff were trained in MAPA (management of actual and potential aggression) to give them the necessary skills and techniques to use, including ways to de-escalate potentially harmful situations.

Nutritional needs had been assessed and care plans confirmed that staff supported people in managing and monitoring their weights. Support was also given with food shopping, eating out, and preparing meals, snacks and drinks. Nutritional risks had been identified and where necessary professional advice was taken from speech and language therapists and dietitians and special diets were provided. Staff told us they promoted healthy eating and exercise and were aware of people's dietary needs. For example, a senior worker said one person they supported had high cholesterol, followed a low fat diet, and was assisted to buy cholesterol-reducing food products.

People using the service described receiving a variety of food, including healthy ingredients, and some people said they were supported to make their own meals. One person told us they had been supported with weight management, exercised by walking a lot and went to a weekly cookery class. They said, "The meals here are lovely." Another person said the staff helped them to cook and commented, "I had help making an omelette on Sunday and it was lovely." Other people told us, "I go shopping to the supermarket with staff", and, "I like cooking and made a curry." One person told us that they and other people they lived with had enjoyed making cakes for a coffee morning to raise funds for charity.

Relatives told us they felt people were appropriately supported in meeting their dietary needs. For instance, one relative said staff had helped their family member to cut down on desserts and have healthier options to help them with maintaining their weight. Another relative said they felt the food was very good and told us their family member went shopping and prepared their own meals. They said that staff helped the person to write and plan menus and that, "They definitely have fresh fruit and vegetables, salads and roasts."

People were provided with appropriate support in meeting their health care needs. Medical history information was gathered and people's health needs and risks had been assessed. Care records showed that staff supported people to routinely access health care services and attend appointments. For instance, we saw a person had a health checklist and calendar with forward planned dates for hospital appointments, visits to their dentist, optician and chiropodist, and when their medicines needed to be reviewed. Detailed support plans were in place which addressed people's health related needs and preventative measures. For example, one person had plans for continence management and the support they needed with a skin condition including district nurse input and equipment. A person we met told us they had arthritis which they took medication for. They were able to get around without walking aids and said staff gave support when needed and had arranged for them to get a special armchair. The service had also ensured that people had aids and equipment, such as shower chairs, grab rails, and mattress sensors to enable their care to be delivered safely.

Good

Is the service caring?

Our findings

People using the service and their families told us the staff were friendly and caring and that they were happy with the care and support. Their comments included, "I'm very happy here. I go out on my own and I'm very independent. I love it. There's a very happy atmosphere"; "It's a lovely place to live. The staff are great and they help you. They do small plans of where you want to go in future. I've never met such a great bunch of staff. You can talk to all of them all the time. My key worker is great if I have any problems"; "(Name) knows all the staff. They all seem pleasant enough and (name) seems to get on with them"; and, "I'm very confident in the staff. (Name of support worker) is very nice and (my relative) has warmed to them. Another member of staff pops in for coffee. They're very friendly."

Our observations and the people we met during home visits confirmed that staff were kind and caring in their approach. The staff spoke to, and about, people respectfully and ensured we were able to meet and talk with individuals in private. Each of the staff we met had a good knowledge of the people they worked with and could readily describe their needs and routines and the ways they preferred to be supported.

A commissioner of the service told us, "I have no issues with how they support service users. We do not have many services with St Cuthbert's but the ones we do have are run well. The staff are supportive and caring."

The manager told us the provider's core values were incorporated within all of the service's policies and procedures. They said good practice was discussed with staff during supervisions and meetings and each shared house had a 'reading file' that staff could access to keep them up to date with new or revised information.

Senior workers had designated roles as 'dignity champions' and promoted dignity through their everyday work with support workers and in supervisions. For example, we saw they had carried out a supervision observing staff to ensure they respected people's dignity during a hypothetical exercise. The manager told us that seniors monitored support workers' attitudes and care practices and reinforced these topics when reviewing performance. The manager and senior workers reviewed care records to check support plans were being followed and that staff recorded issues in a sensitive and appropriate way.

We saw support plans often included specific ways that staff would promote people's privacy and dignity. For example, discreetly leaving a person to undress alone before they went in the shower and supporting a person with personal grooming so they were dignified in their appearance. During reviews of care we saw that people had responded positively when asked about if the staff respected their privacy and dignity, and supported them in making choices and staying independent.

The service encouraged people to be involved in the recruitment of new staff. A person we met told us they had interviewed staff before and were taking part in interviews the following day to help select new support workers. They told us they knew what personal qualities to look for and said, "I know what questions to ask."

Senior workers told us there were stable staff teams and they ensured people were informed about which staff were on duty each day. They said wherever possible they aimed to accommodate people's choices for the staff they wished to accompany them on activities and holidays. A person we talked with confirmed this and said there was a board with the staff names displayed on to refer to and that they chose which support worker to go out with them.

Each person was allocated a key worker from their staff team. Some people we talked with spoke fondly of the relationships they had formed with their key workers. For instance, one person said their worker talked with them about what they wanted to do and said they had been on holiday together and were planning another holiday. Another person said they had monthly meetings with their key worker and that they were good at explaining support plans and involving them in decisions about their care and support. The manager told us that advocacy services could be accessed for anyone who might need support in representing their views.

One person we talked with described how in the past they had not been happy with one of their support workers. They said this had been dealt with promptly by the service at the time. Another person's relative said they had not been particularly happy with the service a couple of years ago and commented, "Things seem to have settled down a lot." The relative told us their family member was more occupied now and commented, "I think (name) would say they are very happy with everything at the moment." The operations manager told us the service valued people's

Good

Is the service caring?

feedback and sought to accommodate their wishes. They said they had, on occasions, moved staff where they had been unable to form good working relationships or develop a rapport with people.

People were given opportunities to express their views about the care they received. They met with their keyworkers to plan and review their support and had annual care reviews which their relatives were also invited to. Tenants' meetings took place in the shared houses and a tenants' forum had recently been set up. Positive feedback had been received to date from the people who had attended the forum about their involvement in the running of the service.

Good

Is the service responsive?

Our findings

People using the service told us they followed their interests and took part in various activities which they enjoyed. They gave us examples of being supported in the community, going to day care services, clubs and attending classes and courses. People's comments included, "I've got a lot of interests and I do all sorts"; "I'm doing a course in customer care at college and the staff help me practice for job interviews"; "I go to clubs and to the library and hairdressers every week"; "I like to stay active and go out on my own. I use the Metro and buses"; "I do work on the computer, arts and crafts and photography"; and, "The things I like best are going to 'live and learn' (a class that promotes independence and teaches social skills held at another of the provider's services) and music sessions. I do voluntary work and go to a place where I learn about work. The staff support me with budgeting and I like shopping and cooking."

People told us they went to the cinema, theatre, concerts and events, a dance group, bowling, gardening centres and football matches. Many people said they regularly went to their local churches and were looking forward to the Christmas celebrations and events. Several people described being supported to do housework and shopping on at least one day per week. Some people said they did not want to go out more as they were so busy, though one person said they would like to go out more in the evenings if there was enough staff. A senior worker in the largest shared house informed us that an extra support worker had been provided to work in the evenings to ensure people were able to go out with support.

The manager confirmed people using the service were supported to access education, voluntary and paid work, and day services where they learned new skills. Care records showed that people had activities timetables, which included support needed, costs and travel arrangements, and care plans for meeting their individual social needs.

Most of the relatives we spoke with said their family members led active lives. They told us people did individual activities and sometimes socialised with one another. For example, going to another shared house for a person's birthday party and attending a fortnightly disco for people with disabilities. A relative told us their family member and quite a few of the other people using the service had been to a fair recently and had gone to the pub afterwards for a meal. One relative commented, "I think television takes over a lot." They told us there was one staff member to look after three people and suggested that more staff were needed to provide social stimulation.

People and their families confirmed they maintained contact with one another. Where necessary, staff provided support such as arranging taxis when a person was going to visit their relative. One relative (who lived a long way from the service) said staff used to telephone them more often. They said staff probably called less often now because their family member's life had become settled after some difficulties. They told us, however, that they would like more telephone calls from the staff, just to let them know their relative was okay. This relative said, "Overall, I'm happy and relaxed that (name) is settled and things are going well."

People's families confirmed they were invited to attend annual care reviews. One relative told us they were aware that the service had produced a booklet detailing their family member's likes, dislikes, choices and goals. They said staff were working towards their family member's idea of where they wished to go on holiday. Another relative told us there was a particular area of care their family member had resisted for many years which staff had managed to successfully overcome.

The manager told us the service responded to people's needs. They gave us an example of how staff had worked with a person who had a dementia-related condition. The service had prompted a re-assessment of their needs and shared support plans and best approaches when the person moved to a nursing home. Some staff had been commissioned to work into the home to help the person settle in and had continued to visit them.

We found the service took a person-centred approach to care and involved people in their care planning. We saw profiles were recorded which gave staff a personalised overview of the individual, their usual routines and how they preferred to be supported. Comprehensive support plans were in place that addressed each person's needs. The plans covered a range of areas including personal care, living skills, nutrition and healthy lifestyle, health and medication, safety in the home and community, finances, and leisure and holidays. All support plans were detailed and described the person's abilities and the level of

Good

Is the service responsive?

support that staff would provide. 'SMART' (specific, measurable, attainable, realistic and timely) plans were drawn up where people had particular goals in becoming more independent based on what they wanted to achieve.

All plans were evaluated monthly and 'positive outcomes reports' were compiled and sent to people's social workers on a quarterly basis. These reports demonstrated where people had achieved outcomes relating to work, travel, home and community integration, and health and exercise. People had monthly meetings with their key workers to discuss their care and support. A 'My Good Life' was also completed with people to measure outcomes and check the quality of their support. This showed people were asked about what was going well and not so well and how they felt about it. They were asked to rate different areas, including making choices and being in control, having friends and relationships, being respected for who I am, and being healthy and staying safe. People were consulted about whether they wanted changes to their support, and if so, staff adapted their support plans.

We saw staff kept daily records that reported on people's well-being and the support they had been given. These included a summary that fed into the reports which were sent to the manager to keep them informed of people's progress. Daily handovers also took place in each shared house to ensure that important information about people's welfare was passed on between staff.

The service's complaints procedure was provided to people in an easy read and pictorial format. Five complaints had been logged in the past year, each from people using the service, and these had been appropriately investigated and acted on. People using the service told us they would talk to the manager or staff if they were unhappy about the service. For example, one person said, "I'd tell X (the senior worker)." A relative told us they had never made a formal complaint but had pointed things out and that the service had responded. Another relative said they had previously complained to a social worker but would now go to their relative's key worker, and said there were no current problems.

During the inspection a relative raised concerns with us about the compatibility of people within a shared house and the impact of shared support, particularly at weekends. They said, "It's gone from utopia to bearable. It's nothing to do with the staff; it's just the way things have panned out." The relative asked not to be identified to the provider so we relayed the issues in a general way to the operations manager to attempt to follow up.

Over the past year the service had received ten compliments, often in the form of thank you letters and cards. The manager told us these were included in her monitoring of the service and shared with staff to ensure they received positive feedback.

Good

Is the service well-led?

Our findings

At the time of our inspection the manager had been in post for three months and they were applying to be registered with the Care Quality Commission (CQC). The manager told us they had received a handover period and had been mentored in their role and responsibilities by the operations manager. They felt well supported by the provider and were able to call upon, when necessary, senior managers and staff with roles for managing risks, safeguarding, human resources, finances, and IT. The manager was based at the largest of the shared houses and visited each shared house weekly, enabling them to be accessible to people using the service and staff.

The manager was studying for a diploma in leadership in health and social care. They had experience of working with a local Healthwatch organisation (a consumer champion in health and care) and been involved in how local authorities implemented care legislation. The manager told us they intended to play an active role in the local authority's providers forum for learning disability services and kept themselves updated with guidance from commissioners. They were committed to developing best practice and had met with senior workers to discuss and agree the standards they expected of the service. The manager told us the senior workers were "very competent" and "a good support" and took on lead roles according to their skills and interests.

The manager said they kept abreast of changing legislation and trends in the care sector and cascaded their knowledge to the staff team. For example, they had team meetings which incorporated training sessions in areas such as health and safety and demonstrating how to meet the requirements of CQC. They also worked collaboratively with other health and social care professionals to benefit the support that people using the service received.

People and their relatives felt the staff and management were approachable. The people we met described the manager as "lovely" and "very nice" and confirmed the manager had visited them in their homes. A commissioner of the service told us they were working with the service to explore the possibility of new accommodation for some people. They said they enjoyed working with the operations manager and had always found them to be proactive and enthusiastic.

The operations manager told us the provider was an employer that positively sought to employ people with disabilities. Measures in place to support staff included an employee assistance programme and recent training for all managers in promoting staff well-being. There were also schemes for staff to 'refer a friend' for employment and for staff to submit ideas to the provider around improving the service.

The staff we talked with confirmed they had regular contact with the manager and felt supported in their roles. They told us, "The manager is really good, plans ahead, and keeps in touch", and, "I can go to them (the management) at any time for support or advice." A support worker said there were regular staff meetings which they felt were productive. They said two meetings were held at different times to make sure staff were able to attend and told us, "We always have discussion and can air our views".

The manager said they aimed to openly communicate with staff, listen to their views, and act on feedback. For example, they had responded to issues raised by ensuring improved communication about changes in rosters to accommodate staff attending training. They had also increased the flexibility of working patterns in line with the needs of the people using the service.

People's feedback about the service was obtained through the tenants' forum and in satisfaction surveys. A relative we spoke with confirmed they occasionally received a survey to complete to give their views about the service. The director of care services told us they had been involved in redesigning the satisfaction surveys for people and their relatives and these were being sent out in the near future. We were shown that action had been taken in response to the findings of the last survey. For instance, the former manager had followed up comments and made sure a person's family was given more notice to attend care reviews with a social worker. A person had also been given practical help so they could have more choice in the television programmes they watched and a plan had been put in place to support this.

A variety of methods were used to assess and assure the quality of the service. The senior workers sent the manager weekly reports that kept them appraised of the checks and audits they had undertaken and any significant events which had occurred in the service. Care records were audited monthly and annual audits of health and safety and finances were conducted. Senior managers carried out

Good

Is the service well-led?

annual quality audits of the services provided in each shared house. These audits covered a range of areas including care documentation and other records, complaints and safeguarding issues, comments and feedback, and staff training and supervision. Where improvements were needed, an action plan was devised that specified the actions to be taken, who was responsible, and dates for completion. The action plans were checked by the manager when they carried out their own audits at each house to ensure there was continuous monitoring of quality.

The manager was keen to continue to develop the service and told us they were working to a business improvement plan. Areas being improved included revamping the guide to the service; developing information for people tailored to their individual needs and levels of understanding; and theming checks and audits to the CQC's standards to take account of people's care experiences.