Creative Support Limited

Creative Support - Manchester Mental Health Services

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 23 May 2018 and was announced. We gave Creative Support – Manchester Mental Health, 24 hours' notice to advise we would visit as we needed to ensure someone would be available at the registered office. This was the first inspection since the service had been registered. The service had operated for a number of years before becoming registered with the Care Quality Commission under the registration of "personal care".

Creative Support – Manchester Mental Health provides care and support to people in 'supported living' settings to enable people to live as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked as people's personal care and support.

Creative Support – Manchester Mental Health supports people with enduring mental health needs. At the time of inspection, there were 10 people receiving personal care living across two services situated in the south of Manchester. Each service supports up to five people at any one time.

There was a registered manager in post however they were not available on the day of inspection as they were on leave. We did speak to the registered manager following the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements on the Health and Social Care Act 2008 and associated regulations about how the service is run.

People were safe while being supported by the service. Appropriate risk assessments were in place to support people and were regularly evaluated to keep people safe.

Staff were aware of procedures in place in relation to keeping vulnerable people safe, they could describe signs of abuse and were aware of the processes in place for reporting any allegations.

Recruitment procedures were robust and staff members were recruited safely.

Medicines were safely managed and audited.

Health and safety of the property. was monitored by the service including fire safety and premises safety. The service continually assessed the property to ensure if was fit for purpose in meeting the needs of the people living there.

There were sufficient numbers of staff members on duty to support the assessed needs of people.

Staff members received regular training and support to enable them to carry out their role effectively.

Staff members were given regular supervision and appraisal.

People received a thorough, comprehensive assessment prior to being supported by the service.

People were supported to remain as independent as possible and were assessed to be able to go out alone and administer medication.

The principles of the Mental Capacity Act 2005 were followed and meetings were held in people's best interests when people did not have capacity or were unable to consent.

There were kind and caring interactions between staff members and people being supported by the service. People told us that they felt well cared for by the staff team.

We observed that staff were respectful to people when talking to them and communicated in a manner in which people could understand.

People were involved in decisions at the service including meal planning, relocation of rooms, activities and budgeting.

Care plans were robust, detailed and person centred. People were involved in their care plans and set goals and aspirations.

Activities were person centred and were encouraged.

Concerns and complaints were responded to in a timely manner and outcomes agreed and shared.

The registered manager and unit business manager had complete oversight of the service, they knew people and the staff team well and everyone we spoke with was very complimentary of them both.

People and the staff team told us that they had full confidence in the registered manager that they would act on any concerns or requests and that they responded promptly.

There were a number of audits in place to monitor and improve the service.

The service sought feedback from people and stakeholders to enable them to monitor improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service is safe.

People received robust risk assessments to enable to them to be supported appropriately.

Staff members and people were fully aware what was expected of them in the event of a safeguarding concern being raised.

Staff members were recruited safely.

Is the service effective?

Good

The service is effective.

Staff received appropriate training, supervision and appraisal to enable them to fulfil their role.

The service continually reviewed the premises to ensure it was fit for purpose for the people they supported.

The service worked within the principles of the Mental Capacity Act and ensured that decisions were made in the best interests of the people they supported.

Is the service caring?

Good

The service is caring.

We saw kind and caring interactions between people and staff members.

People were involved in decisions which affected the service and tenancy.

The service accessed a number of advocacy services to assist people in making decisions.

Is the service responsive?

Good

The service is responsive.

Care plans were detailed, person centred and involved people. People recorded their goals and aspirations within the care plan.

People were supported to attend activities in and outside of the service.

Complaints were responded to in a timely manner.

Is the service well-led?

Good

The service is well led.

The registered manager and the unit business manager had complete oversight of the service. They knew people and staff members well.

The registered manager was in post who had worked at the service for a number of years.

There was a number of audits in place to monitor and improve the service.

Creative Support - Manchester Mental Health Services

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 took place on 23 May 2018 and was announced. The provider was given 24 hours' notice because the location provides personal care and support to adults in different supported living settings. We needed to be sure somebody would be available at the registered office to talk with us. This was the first inspection since the service was registered. One inspector carried out the inspection.

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 the service does well and improvements they plan to make. We looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their views. The local authority had no information regarding the service.

During the inspection we visited both properties in which one property is the registered office. We spoke with the registered manager, the unit business manager, three staff members and four people who used the service. We reviewed two peoples care files including care plans and risk assessments. We reviewed four staff recruitment files, training and supervision records. We looked at records relating to how the service was managed including medicines, quality assurance and policies and procedures.

Good

Is the service safe?

Our findings

People told us that they felt safe while being supported by staff members from Creative Support – Manchester Mental Health. One person told us "Yes, I am safe; they [the staff] are very good." Another person told us, "Yes, I feel safe, I feel protected, the staff are kind."

People told us that they knew who to report any concerns to. One person told us, "I will go to [Registered manager], they are nice." Another person told us that they would speak to staff members if they were worried about anything.

Staff members we spoke with told us that they were fully aware of the safeguarding policies and procedures and could describe what they would do in the event of a safeguarding concern. One staff member said, "I would go straight to [Registered Manager]." Staff members told us that they had full confidence that the Registered Manager would act on any concerns they had. Staff members we spoke with were also aware of the organisational whistle blowing policy and why it was in place. This meant that the service had systems in place to safeguard people from abuse.

The service used a scoring matrix and tracker form when potential new employees were interviewed for a job with the organisation, this prompted the interviewer to check information such as ensuring the application form was complete and the correct documents were seen to clarify identity and right to work. Additionally, the application form had to meet a minimum score of 65% before an interview was arranged. This meant the service was screening people for suitability prior to interview.

We reviewed four staff personnel files and we saw that each staff member had the required pre-employment checks in place including two written references and a Disclosure and Barring Service (DBS) check in place. A DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. We also saw the service had a recruitment policy in place. This meant there were processes in place to protect people from receiving care and support from staff who were unsuitable.

All staff working at the service were responsible for the safe administration of medicines. We saw that staff received annual medication competency checks and attended theory and practical training and received three medication observations before they were deemed competent to administer medication. We saw that where any concerns were raised in relation to the safe administration of medicines, the staff member received supervision and additional training and observations to check their competency. This meant that the service was assuring itself that staff members were competent to administer medicines safely.

We checked three people's medicines and observed a medication round. We found the staff member followed the medication administration record (MAR) and ensured that each person took their medicine with a glass of water.

We viewed three peoples MAR charts and found them to be appropriately completed with photographs of the person on the front. We also checked the boxed medicines of three people and found that stock levels

reflected the numbers recorded on the MAR. We saw that people had protocols in place for the safe administration of "when required" medicine. When required medicine is a medicine such as Paracetamol, which is not routinely required . The protocols gave guidance to staff for the signs and symptoms people may display when in need of this medication. This meant staff were able to monitor people who didn't communicate by looking at other changes in their health and wellbeing

There was a medication support plan in place which identified the level of support people needed for managing their medication. Support plans looked at the persons understanding, compliance and risks of not taking their medicines as prescribed. This meant that the service had identified where people could remain safely independent in managing their medication.

We saw regular temperature checks recorded for fridge and room temperatures which ensured that medicines are stored at the correct temperature. There were monthly medication audits completed which identified excess stock, missing signature and any returns needing to be made to the pharmacy. Any outcomes from the audits were shared with the staff team. There were no errors documented on the last audit completed. This meant that the service was assuring itself the medicines were being appropriately booked in, stored, administered and recorded. Additionally, the service had the patient leaflets for all medicines so they could follow the directions and monitor people for any interactions.

People being supported by the service had risk assessments in place to support them. This looked at factors such as violence, self-neglect, self-injury, alcohol abuse, illicit drugs and inappropriate sexual behaviours. The risk was rated as high, medium or low and there were strategies recorded to assist in reducing any of the risks occurring. There were further risk assessments relating to fire and road safety, allegations of abuse and bathing and showering. A person-centred risk assessment provided information to manage risk to people who used emollient creams which could be flammable and where they smoked or had access to heaters or the cooker. A falls risk assessment was in place to monitor people at risk of falls. This meant the service was proactive at managing risk and reducing the opportunity for risk to occur. Staff members we spoke with could describe the risks each person presented with and how to reduce these risks. For example, one person had previously made a number of unfounded allegations. Staff members could describe that they took each allegation seriously and how they responded in line with the risk assessment. We saw that risk assessments were regularly reviewed.

Staff members were able to tell us how they used de-escalation techniques to reduce people's behaviours from exacerbating. Staff members could describe how they notice when each person's mood is low, for example, one person whose mood dipped in the afternoon, was encouraged to take part in activities and conversation in the morning and given the opportunity to rest in the afternoon. This meant that staff could be responsive to people when their mental health was not stable and offer the appropriate support.

Incidents and accidents were recorded and sent to the wider organisation for analysis. Analysis of the accidents and incidents were recorded and any outcomes were documented and learning from such concerns were shared with staff members. The service looked for patterns and themes and identified what actions could be taken to prevent similar accidents or incidents from occurring again.

The service had an infection control policy in place which gave guidance to staff members on how to minimise the spread of any infection. We saw that staff members had received training in infection control and we were told and we saw that there were plenty of personal protective equipment (PPE) readily available for staff to use.

We saw that the service undertook daily safety checks which included checking window restrictors, that ash

trays were empty, fire exits were clear and the hob was turned off. Weekly fire checks were undertaken which included checking escape routes, checking firefighting equipment, fire alarms, carbon monoxide alarms and emergency lighting. There were regular fire drills for people to ensure they could understand what to do in an emergency. People had personal emergency evacuation plans (PEEPS) in place which gave directions on how to evacuate each person safely.

We saw evidence that where there were concerns with safety, the service had consulted with the landlord of the property and actions were put in place to address the concerns. We saw that the service held copies of the gas safety, electrical installation and portable appliance checks. There was a fire risk assessment in place completed by the service and further assessment from the landlord. We saw that the registered manager and the unit business manager had completed unannounced night visits to the service and held regular fire drills and identified concerns such as one person being slow moving down the stairwell preventing evacuation quickly, this resulted in plans being made to move the person to a ground floor room. They also observed that where someone had a catheter in situ, this could become a trip hazard and the service was looking at ways to minimise this occurring.

We saw records kept for the monitoring of water temperatures and procedures in place for the cleaning and flushing of water outlets.
This meant that the service was proactive in ensuring the premise was safe for people living there.

We saw that there were sufficient number of staff members on duty to support people with their assessed needs. There were always two staff members on throughout the day with a walking night staff during the night. We were told and rotas reflected that further staff members could be brought in to support an activity or appointment. People we spoke with told us that there was always enough staff on duty and staff members we spoke with confirmed this.

Good

Is the service effective?

Our findings

People received a holistic, comprehensive assessment of their needs prior to the service supporting them. This included looking at primary and secondary diagnosis of people's mental health conditions and any triggers that may cause people to deteriorate, including signs of relapse. The assessment contained detailed life and health history including social and housing history and any offending history and also captured people's preferences, for example, having male or female staff members to support them and likes and dislikes.

This meant the service was ensuring it could meet people's needs.

We saw that one person living at the service was hearing impaired. The person did not use any specific sign language but we did see that staff members had developed their own way of communication. For example, when medication needed to be administered, the staff members would point to the keys for the medication cabinet and point up or down to ask where the person would like to receive their medication. We also saw regular interaction with the person with a thumbs up for feeling okay. Staff members were able to tell us in detail about the way the person presented themselves which would give them insight in to the way the person was feeling on that day. Additionally, the person also had a vibrating alarm under their pillow known as a deaf guard. The alarm would activate to wake the person in the event of the fire alarm sounding. This meant the service had devised techniques to communicate effectively and used equipment to enhance the safety of the person.

We saw staff members received regular training in emergency first aid, medication awareness, food safety, infection control, safeguarding, understanding mental health, fire, moving and handling and breakaway techniques. The service had access to the wider organisations training academy and staff members told us they could access additional courses on request and were able to undertake diplomas in health and social care. One staff member told us that they had completed the leadership operations managers training and were looking forward to progressing in their role and another staff member told us that they received regular training and they had really liked it. Copies of training records were kept in staff members personnel files and a training matrix also highlighted where training had been completed or was due.

We saw that there were training courses available for people being supported by the service to undertake, this included subject such as advocacy, managing diabetes, the mental health act, substance misuse, welfare rights and sex and sexuality. No one at the service had currently accessed any of the courses but one person we spoke with said they were aware they were available.

Staff members we spoke with told us and records confirmed that they had received an induction to the service and they had been able to work supernumerary on the rota for a period while they got to know people. Staff members new to care also completed the care certificate. The care certificate is a qualification setting out the knowledge, skills and behaviours expected from care workers. Staff members then went on to receive probationary reviews and regular supervisions. We also saw and staff members told us that they received an annual appraisal in which they were able to set personal goals to work towards. This meant that

staff members received appropriate training, support and supervision to carry out their job role.

People told us that they were supported with meal choices and preparation. Staff members completed the weekly food shop after people had devised the menu between them. We saw that people had requested spam fritters, raspberryade, liver and sausages in the weeks leading up to the inspection and this was reflected on the menu. We observed lunch time in one property and people tucked into home cooked food. One person told us that they looked forward to meal times and "the food is lovely." Another person told us they were able to choose what they ate. We saw condiments available to complement the meal and drinks served with the meal. The atmosphere was relaxed and informal. After the meal, people were encouraged to rate their meal out of 10. On the day of our inspection, one people rated the meal an eight, two people rated it an nine and another a ten. We saw this was recorded after every meal and staff were able to use the ratings when planning meals with people. Care records showed that peoples food preferences were recorded.

We saw that people had their risk of malnutrition monitored and where it was evident that someone was losing weight, they were weighed weekly and referrals to their GP were made. This meant that people's nutrition needs were monitored and any concerns identified were raised efficiently.

Each person being supported by the service had a Health Action Plan (HPA). A HPA is a document that highlights what people need to do to keep a vulnerable person healthy. This includes details of regular medical reviews and tests and signposts to the correct professional if there are any problems with their health. Additionally, each person also had a Wellness Recovery Action Plan (WRAP). A WRAP is a prevention and wellness process that people use to stay well and live their life the way they want it to be. The WRAP lists things that people can do every day to stay safe and well, identify warning signs when their mental health is deteriorating or at crisis and gives guidance to help deal with a crisis.

Each person also had a hospital information pack which gave details to hospital staff in the event of someone requiring admission to hospital. The pack contained information about the person, what support they need, like and dislikes, if they wear glasses or dentures and what is important to the person.

This meant that the service was ensuring the health and welfare needs of people were met and continued to be met in the event that the person required hospital treatment.

People told us that they were able to attend tenant's meetings and we saw minutes where people had identified items for their rooms and discussions had been held about the smoking room which had recently been moved to an outdoor area. We saw evidence that although the smoking room was a valued commodity within the home, people had agreed to move outside with a view to the landlord providing a smoking shelter. This meant that people were being involved in how the property was managed.

We saw that staff members communicated via a communication book, a daily handover at the end of each shift and at staff meetings. Communications from health professionals were recorded in peoples records and as part of the handover.

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. When people are using services in the community, the Court of Protection has to agree to any restrictions on people's liberty. We checked whether the service was working within the principles of the MCA.

At the time of this inspection, there was nobody using the service who had their liberty deprived by the Court of Protection.

The service worked in line with the five principles of the Mental Capacity Act. We saw that people had their mental capacity assessed when there was a change in someone's mental health or a specific decision needed to be made. One person's capacity had been assessed around their understanding of a medical condition that required investigation. The process involved the persons GP as the service wanted to assess if the person would ever regain the capacity to make the decision. We saw that the person had been encouraged to participate in the decision making and then a decision was made in the persons best interests.

We saw that people had consented to receiving support with personal care and contributing and holding house hold accounts. Where people could not consent, best interest's meetings were held to clarify what was in the persons best interests. These meetings were fully documented with outcomes.

This meant that the service was acting in accordance with the Mental Capacity Act 2005 and ensured that where people could not make decisions, that the service did so in their best interests.

Good

Is the service caring?

Our findings

We saw that people using the service were encouraged to be involved in interviewing for new staff members. People were encouraged to ask their own questions to potential new employees and find if they and the interviewee had any shared interests which would complement the support needs of the individual. For example, one person told us they liked football and enjoyed being supported by staff who liked football as they could have regular conversations about the subject.

One person told us "We are well looked after here, the staff explain things to us, they are very good." The person went on to say that they had requested a birthday meal and a cake at a local venue which had then been organised. Another person told us "I like living here, I do different things, I feel safe and its clean and I choose what I want to do. The staff are kind and [Registered Manager] is nice."

We saw that a person had been supported to maintain relationships with an elderly relative being looked after in another care service and staff members had supported them to visit the relative and implemented additional checks on the person to ensure the visit had not impacted on their mental health and wellbeing. Another person told us that they were looking forward to their relatives visiting and that they were staying in a local hotel so they could spend time together. This meant that the service encouraged people retaining relationships with family.

We saw that people being supported by the service interacted with each other and staff members throughout the inspection. We observed kind interactions and meaningful conversations about plans for the day. Staff members were patient with people and where people did not want to engage in discussion, staff members gave them time and space. We found staff members to be observant and responded to people in a timely manner when it was requested.

People told us and we saw that staff members knocked on doors and waited to be given permission to enter rooms and held private conversations away from others. We also saw that people were listened to and their opinions valued and respected. We observed people to be well dressed for the weather conditions and observed people being encouraged to attend to their hygiene needs.

The service was an advocate for dignity champions and followed the 10-point dignity challenge. We observed that staff were dignified in their approach to people and engaged to people with respect.

Where concerns had been identified regarding the safety of the property, we saw that people had been involved in making decisions. For example, there was a room within the property available for people to smoke in. The registered manager had assessed that the risks to people who smoke, passive smoking and fire risk were high and held meetings with the group to raise these concerns and weigh up the positives and negatives of having a smoking room and moving it to an outdoor area. Once all the reasons were discussed, it was agreed that the smoking area would be moved outside and a shelter would be purchased. We also saw that people had been able to request their room to be decorated which had been actioned promptly. This meant that people were involved in the planning and able to share their own ideas.

The service had access to a number of advocacy services and we saw that one person had been supported by an advocate in relation to changes to their care plan. Another person had been supported by an IMCA (Independent Mental Capacity Advocate) in relation to a health concern. Also, the service had recently relocated one of their properties. We saw details of meetings with people, their families, health professionals and representatives discussing the move and identifying more suitable properties to meet people's needs. People were able to ask questions and make their views known. This meant that the service had processes in place to enable people to independently have their voices heard.

Personal information relating to people using the service was safely locked away in an office to prevent breaches of confidentiality.

Good

Is the service responsive?

Our findings

We saw that people were receiving primary working sessions with their keyworker where people were able to discuss reaching their goals in a one to one session. One person wanted to go out to experience different foods at a local restaurant, the person had not been able to do this for some time due to anxieties. The keyworker supported the person to make the steps to find a local restaurant, review the menu and opening times and plan the date and time of visiting. Once they had been on the visit, the keyworker and person evaluated what went well for them and what could be done to improve the experience and discussed how the outcome had improved their life. For this person, they said that they had gained more confidence and were in the process of planning a visit to another food establishment. This meant that people were been supported in a person centred way to reach personal goals and given the skills to achieve them.

Each person was assessed for being able to access the community unsupported. We saw that one person wished to go out on their bicycle and they had been assessed for road safety. This meant that the service was ensuring that the person could remain independent while staying safe.

The primary working sessions were also held to discuss activities with people. We saw there were regular trips out for lunch and people were supported to attend group day trips to Blackpool and Hollinsworth Lake. One person told us that they wanted to go to a football stadium and we saw that they were in the process of planning the trip with staff. One person received regular reflexology sessions with a trained reflexologist, they told us that they looked forward to the sessions to help them to relax.

Additionally, the primary working sessions assisted people to plan for the future, this included managing finances and budgeting, looking at access to educational and activities. For example, the service supported one person to plan for paying their rent. Staff members would mark on the calendar when the rent was due and the person would be supported to go to the bank to draw out money. Another person had worked with staff to devise a budget plan to ensure they had enough money to purchase cigarettes and have money left over each week for any additional items. People could also plan within their budgets plans for paying for Sky TV or other services. This meant the service was empowering people to manage their monies and retain independence when managing money. We saw that all monies entering the property were recorded and receipted.

On the day of our inspection, one person had requested a fan for their room. We observed a staff member look at various fans available and gave the person the opportunity to approve the fan they would like to order. This meant that the person could have choice and autonomy over their purchases.

We saw that people were involved in developing their care plans, reflected current needs and were personalised. They captured people's choices, likes and dislikes and why the person would be vulnerable to others. Care plans included information such as what was important to the person, what they enjoyed doing, how best to support the person and how to keep them safe. One care plan we viewed contained information about the person's dislike of needles and gave strategies for supporting the person in the event of having a blood test or injection. Another care plan described how staff members could be put at risk of

allegations of abuse and gave detailed information on how to deal with allegations while still keeping the person safe. Further care plans pertaining to personal and self-care, the management of anti-social and inappropriate behaviour, mental health support, physical health support and daily living skills were detailed and evaluated monthly or more often if required. We saw care plans relating to daily living skills highlighted what people can already do, for example, make a light snack or any goals they wanted to work towards such as cooking a meal.

People had person centred plans in place which described what was important to them, who was in their life, how they make decisions, what makes a good day or a bad day, when is not the best time to ask them things, what characteristics staff members need to support them and what people liked and admired about them. We saw for one person that it was important to them to be able to go to the shop daily for a newspaper which they did. Another person's plan said that people admired that they were always dressed smartly. Plans had been drawn up and implemented by people chosen by the person and themselves.

This meant that people and staff members had the care and support plans they needed to support people to live their life fully.

We saw there were protocols in place within the care plans for dealing with missing people. This included a recent photo of the person, a full description of any distinguishing features, allergies and medicines they may require. This meant the information could be given the police or other authority's quickly.

All the people we spoke with said they were aware of how and who to complain to. One person said, "I will go to [Registered Manager] but I have no complaints, I can choose what I want to do, eat, I have a nice bedroom with Sky TV."

The service had a complaints policy in place. People living at the service told us that they were aware of the procedures should they wish to make a complaint. We saw that the service had received two complaints since being registered with the Care Quality Commission (CQC) and there were three compliments recorded. The complaints were from people using the service in relation to their meals. Both complaints were responded to promptly with outcomes shared to the complainants.

Compliments we viewed were from professionals visiting the service which said " [Person] is more settled and happier [at service]. They are cleaner, more presentable and [Name] is thriving under a routine." And "The staff are warm, friendly and approachable. I have observed the staff to have the best interests of the clients at the forefront of care and promote their interests in activities to increase their wellbeing in the community."

This meant the service had processes in place to allow people to complain and systems in place to process and resolve concerns made via a complaint.

We saw that people had plans in place to support them at the end of their life. Some people supported by the service had chosen not to complete them but where people had, the plan the instructions that should be followed in the event of death, plans for the funeral including any flowers, readings and venue. It was also documented who should be involved with the person at the end of life. This meant the service had plans in place to support people as they neared the end of life.

Good

Is the service well-led?

Our findings

We saw that the Registered Manager was supported by the Unit Business Manager (UBM) who assisted in facilitating the inspection. We found the UBM to be knowledgeable about the people using the service and told us that they had an open-door policy for all people and staff members and that nothing was too silly to be raised with them. We observed staff and people using the service were at ease when talking with the UBM.

There were monthly staff meetings held for staff members and the senior team. We saw that meeting minutes gave leadership feedback to the wider staff team and staff were able to contribute to a set agenda. The agenda covered health and safety, the finding of inspections and audits, health and wellbeing of staff members and service users and paperwork such as risk assessments. This meant that information was cascaded to staff members to keep them up to date.

Staff members we spoke with were very complimentary of the Registered Manager and the UBM. One staff member told us "I love it here, we have a great team and the staff are amazing, they really care about the people and [Registered Manager] is very respectful and inspiring."

Staff members told us that if they felt they required additional training or identified a new training that could help their role, they could take it to the Registered Manager who would listen and endeavour to access the training. Staff members told us and records confirmed that the Registered Manager provided them with regular supervision, performance appraisal, training, handover and staff meetings. This meant the staff team had the support needed to enable them to carry out their role effectively.

The staff team was stable with a low turnover of staff which meant there was continuity for the people being supported by the service.

We saw that people using the service were given the opportunity to complete surveys and all responses said they have trust and confidence in the service and that people felt they were treated with dignity and respect.

We saw that people, staff members and managers were given a copy of the wider organisational document "Code Red." Code Red is a one-page document that sign posts others to raise concerns within the organisation as well as making people aware that they can raise concerns vis the staff team, registered manager, family, professionals, the local authority and the Care Quality Commission. People and staff members, we spoke had been made aware of Code Red via meetings held with the Registered Manager.

A robust quality assurance system was in place. A number of audits were completed by the Registered Manager to ensure the safety of people using the service, this included health and safety, audits of medicines, supervision audits and financial audits. These audits linked with the Care Quality Commission (CQC) Regulations and were used to ensure that the service was responsive to the areas they covered. We saw audits were completed regularly and where any concerns were highlighted, an action plan was put in

place to improve the concern.

We saw that the senior care staff members completed a weekly report for the Registered Manager to ensure they were aware of any incidents, significant issues, staffing issues, environmental issues and training. This meant that the Registered Manager was assured they were aware of any significant information

The service had worked with the Clinical Commissioning Group (CCG) and The Commission for Quality and Innovation (CQUIN) to improve outcomes for people they support. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. It aims to improve quality and outcomes for people using services including reducing health equalities. One year, the service supported people with smoking cessation and the service had to evidence how people had been supported to give up or reduce how much they smoked. Reports are sent to CQUIN annually and noncompliance with CQUIN could affect funding.

We saw that the senior managers visit the service quarterly and completed audits to ensure the service was effective. They also looked at previous actions and ensured that anything identified had been implemented.