Outlook Care

# Outlook Care - Unit 6 Shelduck House, Billericay

## Inspection report

Unit 6, Shelduck House
Woodbrook Crescent
Billericay
Essex
CM12 0EQ

Tel: 01277633163
Website: www.outlookcare.org.uk

Date of inspection visit:
11 July 2017
12 July 2017
13 July 2017

Date of publication:
20 September 2017

## 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? | Outstanding ☆ |

# Summary of findings

## Overall summary

The inspection took place on 11 to 13 July 2017 and was announced.

Outlook Care provides personal care to approximately 150 people with learning disabilities in a variety of supported living schemes. The service does not provide nursing care. People required a varying level of support, from people who required minimal input to continue remaining independent to people with more complex health needs. The schemes included shared houses and blocks of individual flats situated across East London and South Essex. We were not inspecting the accommodation, which was managed by a number of different landlords.

A registered manager was in post at the service. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager was a passionate leader who put people at the centre of the service. There was a focus on continuous improvement and developing best practice to promote the wellbeing and safety of people in the service. There were robust and wide ranging systems in place to check the quality of the service and information from these checks was used to improve the service. The registered manager had helped build strong, value based foundations which had the potential to develop an outstanding service.

There was a focus on people being central to decisions around safeguarding. People were supported to take risks and increase their independence in a safe way. The provider had a robust recruitment process to protect people from the risk of avoidable harm. Staff deployment ensured people were supported by staff who knew them. There were sufficient numbers of skilled staff to support people in a flexible manner. Staff supported people to take their prescribed medicines safely. There were measures in place to support people who wanted to take medicines independently.

Staff were skilled in meeting people's needs. Bespoke training was developed in line with best practice and with the involvement of the people being supported. The managers communicated well with staff and supported them in their role. People were enabled to make healthy and safe choices about what they ate and drank. The guidance in place to prevent choking was exceptional. Staff worked well with outside professionals and supported people to access health and social care services when needed.

Managers and staff worked well within the Mental Capacity Act and supported people's to make safe choices. Where required, correct procedures had been followed in line with existing legislation. There were effective tools in place to assess people's capacity, which took into account people's communication.

Staff were caring to people in a manner which empowered them and promoted their independence. People were communicated with as individuals and where they were not able to communicate verbally, staff used

alternative forms of communication. Their rights and dignity were respected. People had access to independent advocacy both as individuals and in groups.

People received support that was personalised around their needs. Staff had the necessary information to support people in a flexible manner, reviewing and adjusting support to meet a variety of needs within each scheme.

People and families were aware of how to make a complaint and were confident these would be responded to positively. The manager had developed an exceptional array of opportunities for people to express their views and give feedback about the service. There was a commitment to best practice in this area and the manager constantly drove improvements and innovations to ensure people were at the centre of developments within the service.

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

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff were vigilant about keeping people safe. People were supported to minimise risks to their safety.

There were sufficient staff to meet people's needs.

Staff supported people to take their medicines safely, encouraging independence where appropriate.

### Is the service effective?

Good

The service was effective.

Staff skills were developed in a variety of ways.

People were enabled to make their own choices. There was a good understanding of the Mental Capacity Act.

People were enabled to eat and drink safely and in line with their preferences.

Staff worked well with health and social care professionals to promote people's health and wellbeing.

### Is the service caring?

Good

The service was caring.

Staff cared and communicated with people as individuals

Staff had respect for people's privacy and confidentiality.

Access to advocacy was promoted.

### Is the service responsive?

Good

The service was responsive.

People received support which was personalised around their individual needs and desired outcomes.

Staff promoted people's independence and enabled them to develop skills.

People knew who to speak to make a complaint. They were given varied opportunities to provide feedback, in line with their individual method of communication.

## Is the service well-led?

**Outstanding** ☆

The service was exceptionally well-led.

The manager was a strong leader who ensured people were at the centre of the development and management of the service. They were supported by a committed team of managers and staff.

There were a number of highly effective measures to check on the quality of the support, which resulted in improved outcomes for the people in the service.

The manager continually focused on seeking out best practice and developing innovation in the service.

# Outlook Care - Unit 6 Shelduck House, Billericay

**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 11 to 13 July 2017 and was announced. We gave 48 hours' notice as we needed to make sure the right people were available to speak with us. The inspection was carried out by three inspectors and two experts by experience. One expert by experience was a person who has personal experience caring for someone who uses this type of care service and they carried out phone calls to people who used the service and their families. The second expert by experience had personal experience of using services and they visited a scheme with us.

On the first day of the inspection two inspectors visited the office area where the registered manager was based. We met with the registered manager, two service managers, the training manager and other office staff. On the second and third day of the inspection we visited three schemes and met with people who used the service and the staff and managers who supported them.

During our visit there were people we met who chose not to speak with us and so we used observation as a main tool to find out about the service they were receiving. 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 reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including the local authority. We used this information to plan what areas we were going to focus on during our inspection.

We looked at ten people's care records and ten staff records. We examined information relating to the management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and information about complaints. We spoke with a member of the board and had email contact with five professionals.

Good

# Is the service safe?

## Our findings

People told us they felt safe at the family and we observed that they were at ease with the staff who supported them. A person told us, "I feel safe; I would speak to the manager if somebody was not being nice." A family member had described an incident where there were concerns over a person's safety. They told us, "We were informed straight away. The police were involved and an investigation took place. We were happy with the way they handled the situation." Another family member told us, "I feel my relative is very safe, I have absolutely nothing to worry about there."

Prior to the inspection we had reviewed the safeguarding alerts made to the CQC and noted that the organisation was pro-active and open. They had a good oversight of the schemes where safeguarding was a concern. For example, they had retained management of one of the schemes so they could personally deal with specific issues. They described how they visited a scheme on a Sunday to provide on-call support when a person had become distressed and presented a risk to themselves and others. They wrote a quarterly report and accompanying action plan about safeguarding alerts at the service. There was an innovative approach to promoting safety. For example, a recent action plan had made the online staff safeguarding training available to all families, so that there could be shared responsibility for keeping people safe.

The manager described how there they were promoting a culture in the organisation around safeguarding which was more person centred and was focused on achieving the right outcomes for a person, not on the processes. The manager described how where appropriate people and their families were invited to at least part of safeguarding meetings that previously had been held with professionals so that they could say what they wanted out of the investigation The manager described positive feedback they had received about the importance of this process from relatives and the wider family.

Staff had attended safeguarding training and the staff we spoke to understood how to protect people from harm and were aware of the signs that could alert them that someone was being abused. Staff knew how to report concerns and were confident that if they raised a safeguarding or whistleblowing alert the management team would deal with their concerns promptly in order to keep people safe. A member of staff told us, "I would report to senior management, if I was not happy I would go to the safeguarding team at the local authority." We saw in team meetings that staff were given an opportunity to speak separately to a manager when it was felt they might not speak up about a specific concern in a meeting.

The provider had systems in place for assessing and managing risk. Staff completed a wide range of risk assessments and robust, person centred risk management plans were in place which provided staff with information and guidance about how to support people safely. For example, a person with epilepsy had detailed plans in place to minimise this person's risk from harm. They wore a pendant during the day and had an alarm in their bed to alert staff to any seizures. Their epilepsy was well managed and staff contacted the epilepsy nurse after each seizure.

Staff balanced the importance of minimising restrictions to people's independence, whilst still keeping them safe. For example, a person liked to have a bath independently but had agreed with staff that they

would let staff know when they were having a bath and make sure there was a non-slip mat in place. They were also independent with their cooking however, staff stood with them while they cooked, and had to remind them to use oven gloves.

Where mistakes or concerns had occurred, the service had a pro-active approach to learning and improving. A review into an incident involving a person's safety had led to improvements across the service. For example, a one page risk map had now been introduced for each person summarising the main risks staff should consider when supporting them. Family members told us staff were vigilant when supporting people. One family member told us of a specific risk to their relative and said, "They seem to be managing it well at the minute."

The service had a robust recruitment policy in place to ensure that staff were recruited safely. Each staff member had to attend a face to face interview and all the required employment background checks, security checks and references were reviewed before they began to work for the organisation. This process ensured the provider made safe recruitment choices. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

There was a team of bank staff who provided cover when the usual staff were off. The manager told us this enabled them to be assured the staff had been inducted to the same standard. It also meant people could be cared for by staff who were familiar to them as bank staff tended to work in the same location.

There was a focus on ensuring the people who worked for the organisation had the right skills and attitude. People who used the service were actively involved in the selection process. The manager described a recent recruitment event where they had arranged for candidates to spend a day with people, doing cooking and other activities. The successful candidates were selected based on their ability to connect well with people. If a certain home was having a recruitment drive then some people from that service took part in the interview process. During a visit to a scheme we met a person who described how they took part in an interview for a new member of staff, who was now supporting them. A member of staff we spoke told us they felt staff selected from this process were far more appropriate and worked better with people than in the past.

Staff were available and had time to support people. People told us there were sufficient staff on duty to respond to their needs. People said, "There's always someone when you need them" and "Staff don't rush they seem to have time." Family members told us, "The staff are excellent they never seem like they are rushing and always have time to chat to us" and "When I have visited, the service users are safe and well looked after, there are always a set number of staff on duty at any time."
Some people supported by the service were independent and went out without support, but staff were available to escort people to activities or events where they required support, for example health appointments.

People received their medication safely. A person told us, "They give me my medicines when I need them I always get them when I should. I never missed any." A family member said, "My relative gets his medication at set times we have only had one occasion some time ago when his medication was missed and they informed us and the GP."

People's medicines were managed safely by trained staff who were regularly checked to ensure they were competent. Weekly and monthly medicine audits were completed to monitor the safe administration of people's medicines. These included examining any medication errors to check the risk of them re-occurring

had been minimised.

We checked medicine records and found that people were receiving their medicines as prescribed. People had medicines administration records (MAR) for medicines and creams, which were accurate and contained no gaps. We highlighted to the team leader in one of the schemes that medicine information which had been handwritten had not been double signed, which they agreed to address, in line with best practice.

Staff had advice on how to support people with their medicines. For example, they were advised to engage people in conversation after taking their tablets to ensure these had been swallowed. Where a person had complex needs we saw that guidance was extremely personalised. Their plan advised staff to "Place a small straw in an egg cup, hold this up to me, place the straw gently in the person's mouth."

Protocols providing guidance on the use of "as required" medicine were not always in place, particularly for more independent people. One person's care plan stated pain relief was to be given 'as required,' but did not provide further guidance to staff. We spoke with the person and confirmed, as outlined in their care plan that they were able to communicate when they were in pain. In a second example, people in a scheme had capacity and were able to ask for pain relief or other medicines verbally. However, we discussed this with the team leaders of each scheme and they agreed to amend the care plans to provide improved guidance to staff to ensure decisions around 'as required medicines' were made safely.

People were actively supported to manage their medicines independently, where appropriate and were at different stages of this process. There was an Individual locked medicine cupboard in each bedroom. Where a person wished to self-medicate staff had pro-actively supported their independence. For example, they had marked with a pen on the medicine cup the right levels for the person to pour their liquid medicines. Staff had taken advice from health professionals to assist the person in devising a safe routine when taking their medicines.

The registered manager had researched best practice and told us they were committed to the campaign STOMP (Stopping over medication of people with a learning disability, autism or both). In practice, this meant staff were required to be aware of levels of medication and people were supported to request a review of their medication when necessary.

Good

# Is the service effective?

## Our findings

We observed staff were skilled in supporting people and meeting their needs. A family member told us, "I would think that they are all very well trained, they understand my relative very well and 'interpret' for me. I have been to various meetings such as her personal development plan and am impressed with their professionalism."

Staff told us the training was of a good standard and enabled them to support people effectively. Staff said, "Training is a mixture of online and face to face, NVQ 3 is encouraged and most of us have this" and "The service manager and team leader have been great. I have not been thrown in the deep end and do not feel worried about anything at the moment." Staff received regular competency assessments whilst carrying out their role. Staff told us that they were supported and received supervision regularly. A member of staff told us, "We have team meetings every month, and the registered manager does my supervision, I do feel supported."

All new members of staff completed an induction programme and spent time shadowing more experienced colleagues and getting to know people before supporting them. Before working independently, observations of practice on new staff were carried out to ensure that they had the necessary skills to care for people. The manager told us there had been a review of skill levels when staff transferred over to the service, for example if the organisation took over the management of a scheme from another provider. Measures had recently been put in place to make sure these new staff had the same skill levels as existing care staff.

Training was monitored centrally to enable managers to ensure there were no gaps in staff skills. There was a dedicated training manager who ran courses but was also available to provided support in a more creative manner, for example team building or additional coaching for newly promoted team leaders. They worked with small groups of staff mentoring them to enable them to achieve the care certificate, which was in place to ensure core skills were achieved. Senior managers developed training to take into account different learning styles and therefore enabled staff to reach their full potential with the necessary support. For example, some staff were able to prove their competence within the care certificate through informal discussion rather than having to repeatedly answer set questions.

The training provided to individual staff reflected the culture and standards of the wider service. A newer member of staff told us one of the main expectations of their role was to encourage people to be independent. A family member confirmed this, "Our relative needs to be encouraged to do be more independent and the staff try to help him, he needs to be encouraged to get up and dressed for example." There was a focus on striving for best practice and senior staff had worked alongside a local college to compile a six to eight week course that enabled them to support team leaders and new managers in their job role, for example covering modules such as how to manager poor performance and how to cope with stressful situations.

The focus on involving people in developing their own service was also evident in the training of staff. A person delivered training on Values and the Mental Capacity Act. Another person was in paid employment,

working alongside the training manager and had responsibility for setting up the IT equipment. A person with complex needs had taken part in compiling a training video and was filmed telling staff how they would like their care needs met and the support required. Feedback from staff who had watched the video said they found this invaluable because they had actually watched and heard from the person themselves what they wanted rather than just read about it.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

There was a good understanding of the requirements of the act and staff focused on ensuring people's human rights were maintained. The manager told us they have been reviewing historical decisions made about capacity for new people they had started to support, to ensure they were still appropriate. There are specific procedures involving the Court of Protection where people are deprived of their liberty within supported living services and we saw that these had been followed as required. For example, an application had been made to the court of protection for a person who was under constant supervision for their own safety when out in the community.

Where appropriate, staff had assumed people had the capacity and right to make their own decisions. Where this was in doubt, staff used a highly effective tool to assess people's capacity. When a person was assessed as not having capacity, the capacity tool gave staff advice on what process to follow. Capacity assessments were reviewed as required. We saw on people's care records that where appropriate all decisions around capacity involved family and outside professionals. One staff member said, "People here have capacity, but if we are ever in doubt we would liaise with their care co-ordinator. Best interest meetings would include all relevant professionals."

The mental capacity assessment tool considered what communication was needed to ensure people understood the decision they had to make. A person had been assessed as needing staff support to understand medicines. However, if staff described the benefits and risks of each medicine, they were able to make a decision about whether they were going to take it. We spoke to the person and saw they were able to point to their stomach when asked why they took their medicine.

People were supported to eat and drink healthily. People sat individually with staff and planned their meals and shopping for the week. People had somewhere to store their own food, though some people pooled their food to have a roast dinner on Sundays. Plans around eating were personalised. People ate when they chose and had their favourite take away on different days. Staff told us one person liked to 'grab' a packet of crisps so staff had sat with them and cut up fruit into pots. The guidance in the support plan now stated staff should encourage them to "grab a pot" instead of crisps.

Guidance was given as to the specific support needed to ensure people maintained their independence. For example, in one person's care plan it stated the person only needed advice to check food was properly defrosted and cooked. People told us, "I do my own shopping and cooking" and "I get my own shopping and can choose what I want to eat, sometimes I cook my own food with the staff helping me."

The manager told us as modified diets were often unattractive they were working with other professionals to support staff to make them more palatable. When we visited a scheme we saw this in practice, staff told us how they had adjusted a person's food as their health deteriorated. The person was no longer able to

communicate but staff knew their preferences well and arranged the blended food attractively to try to encourage them to eat.

Staff had a holistic approach to people's health which was demonstrated throughout the support provided and in individual care plans. For example, one person was encouraged to walk to the shops when staff were supporting them with shopping so they could get more exercise. Another person was diabetic and staff supported them to attend appointments with the diabetes service. Staff had been encouraging them to follow a healthy diet and there was recent evidence that medication has been decreased.

People's care records showed the involvement of health and social care professionals. Staff worked with various agencies and made sure people accessed other services in cases of emergency, or when their needs changed. A person told us, "If I need the doctor or dentist the staff will book appointment for me, and make sure I get check-ups." A family member told us, "They will sort out any appointments and they always keep me informed, communication is very good."

Staff followed advice and guidance provided by external health and social care professionals. Where a person had a health condition there was guidance in the care plan to help staff understand how to support them. The guidance was also available in a more assessable format, so that the person was also provided with appropriate information about their health. One person had advice on how look after their gout, with a picture of a stool and a foot resting on it.

Good

# Is the service caring?

## Our findings

People told us they were supported by kind staff. One person said, "The staff are lovely I couldn't ask for nicer people." A family member told us, "The staff all seem very kind I have never seen anything different." During our visit a person wrote us a letter about their favourite member of staff. The letter said, "She always makes time for me and always talks to me. I do get myself upset, but [staff] holds my hand and reassures me. I can trust her and now I'm not crying as much."

People benefitted being supported by staff with in-depth understanding of their individual needs and preferences. Staff introduced us to people so that they were not anxious or uncomfortable. A family member told us they their relative liked their own company but had, "A very good relationship with his key workers which they value very much." A health and social care professional said, "The relationships staff have with the residents are clearly special; the way that they interact with them and how they are presented." Our observations and discussions with staff confirmed they were gentle and compassionate. For example, where a person's health and quality of life had deteriorated through dementia, staff spoke with fondness and sadness, as if they were speaking of a member of their family.

Staff were skilled at communicating with people and understanding their needs if they were not verbal. A member of staff told us, "We know when [person] wiggles about that they want to go to the toilet." A variety of tools were used to aid communication. One person had been assessed as being at risk if they misunderstood what staff were saying so the care plan stated, "All information given to [person] will be in large print or pictorial format and they will be spoken to by staff to ensure their understanding." This positive approach to communication meant staff supported people to fulfil their independence and to make choices about their life

The support had been designed to ensure people were as independent as possible. Tasks were split in care plans to enable people to be fulfil their potential. For example, one person would strip their bed independently and then staff would support them to re-make the bed. People we spoke to described how they managed their money when out shopping; they held their own purse and paid for things themselves and staff would help them check their change. A family member told us, "They help my relative to try and become more independent though they do require a bit of prompting."

When staff spoke with us they were respectful in the way they referred to people. We observed a person becoming very anxious during our visit. A member of staff said, "[Person] is very intelligent and knows exactly what they need and who to ask. They drive the communication when they want something to happen."

People's confidentiality was upheld, and the importance of this was emphasised in the organisations values, which had been developed by people who used the service. A person told us, "Staff only talk to me about my needs not others." People had their own key to room and where people were more independent staff checked rooms with people as part of their support. A person told us, "I can lock the door and the staff do knock on my door before they come in."

People were supported to maintain on-going relationships with their families and visited them independently. They were also supported to access formal advocacy if necessary. An advocate supports a person to have an independent voice and express their views. Where staff were monitoring a person due to concerns about their behaviour, there were clear records of communication with advocates and families, which helped protect their rights.

Good

# Is the service responsive?

## Our findings

Support was based on individual needs and preferences as agreed with each person. A person described how they set their daily timetable and said, "I decide when I get up I get myself showered and dressed." A family member told us, "They are not rigid on doing things at certain times, it's very nice and laid back."

People's care needs had been assessed before receiving the service, which helped to ensure the service was able to meet their needs. A one page profile had been developed to summarise what should be at the forefront of a staff members mind when they supported a person. People had been involved in the planning of their care through the assessment and care planning process. One person said, "I have a care plan I go to the meetings about it and they ask me if I'm ok with everything." People kept a copy of their care plan in their rooms. Staff spoke about care plans as belonging to the person, so staff asked people's permission when we asked to see records when visiting a scheme.

Plans were person centred and included achievable goals. In one of the schemes staff told us that people selected a 'skill teach', which was a skill they were working on. We discussed 'skill teach' with the people at a scheme and they all knew what theirs were. For example, people told us, "Mine is shaving", "My skill teach is tea making" and "My priority is crossing the road safely."

Staff completed daily records summarising the support provided. Reviews took place monthly or as required and summarised the support people had received. Families and professionals were involved as appropriate. There were clear notes summarising what had changed since the last review and what actions were needed. For example, one person's review stated that staff had helped them buy the new furniture which they had asked for and there was a new action to support the person to go to their GP. Following the review we saw specialist support was set up. The advice from this appointment was then used to adapt the support plan, for example to adapt the dietary advice being given to the person.

There was also a section in the review which said, "What support did not go so well." We found this was an honest account, for example in one person's review there was a discussion about a medicine error which had occurred. As a result of this incident, staff had written easy to follow medication guidelines for each person who they supported with medicines and these were attached to medicine record sheets.

People described how support from staff enabled them to live a full life of their choice. The way support was organised varied between the types of scheme. In the smaller schemes, staff worked flexibly with people to meet their needs. This provided personalised and responsive support. We also visited a larger scheme where support was more formalised to ensure everyone's needs were met fairly. Staff had 'support cards' with allocated tasks and people to support. Whilst this initially appeared prescriptive and task based, staff told us, "In the past you worried you had forgotten someone. Now you know everyone is covered." Another member of staff told us, "This is the best thing that ever happened." The support cards ensured support was tailored to people's needs. For example, they had tasks such as, "Check [person] has had their bran flakes" or "Every five weeks they need to go to the barbers." The support cards were reviewed regularly with people and tweaked as necessary. Additional, more flexible support was offered, where staff were available on an

adhoc basis.

Staff enabled people to engage in activities of their choice and to become integrated in their local community. For example in one care plan, staff had recorded the person had received their voting card and what support was needed to enable them to vote. Another person told us, "I've got a job; I make tea and coffee at the club." A member of staff then added, "They make a lovely cup of tea for everyone at the scheme." Activities were varied and purposeful, for example people told us, "I go shopping and bowling and I help water the vegetables" and "My support worker [named] helps me with my room on Sunday, and to buy clothes."

People were encouraged to take place in events which brought them together and reduced isolation. For example, in one of the schemes staff organised a 'Come Dine with me' experience, where two people took it in turns to share a meal and watch a TV programme or play a game together. The meal included vegetables which the people had grown in their garden. This was highlighted in the organisation's magazine and encouraged as an example of good practice.

Complaints were taken seriously and the service was constantly seeking innovative ways of gathering people's feedback. Senior staff responsible for responding to complaints had received training on how to respond to people to ensure complaints were investigated well and resolved positively. A complaints log was in place, tracking themes from concerns raised and responses to complaints. Compliments were welcomed and used positively to reward staff and share good practice.

Welcome packs had information about how to complain and we saw people used the complaint process and this made a difference to their support. As a result of a complaint staff had arranged for a police officer from the safer neighbourhood team to visit a person. Where appropriate, complaint responses were communicated verbally or by using pictures, such a picture of a police officer, to ensure a person knew their complaint had been looked into.

People told us they felt able to speak out when unhappy. A person told us, "If I have any problems I speak to my key worker and they always sort it for me." A family member said, "I know how to make a complaint the manager always makes sure we are happy with everything and is very open about the complaints process." Another relative told us, "I have not had to complain, but if I have raised a question of any sort, it has been answered to my satisfaction."

Outstanding ☆

# Is the service well-led?

## Our findings

This was a service which constantly put people at the centre of the organisation. We saw that people were central to developing the service, not just passive recipients of support. People described to us how they had interviewed new staff, carried out audits of the quality of care provided and developed training videos to communicate to staff about their needs.

Representatives from different schemes were involved in developing new standards which set out how they wanted to be treated and what was important to them. For example, one standard was that people could be involved in selecting new staff. During our inspection we met a number of people who had helped select staff at their scheme and the Chair of the Board was interviewed by a panel of people who used the service. Where people had more complex needs and could not be part of the usual interview panel, the manager had arranged activities where applicants were assessed as they interacted informally with people.

Since our last inspection a carers committee had been set up to ensure family members shaped how the service worked with them. Standards had been developed which formed part of staff induction so they were aware of the carer's perspective. One standard stated that families wanted to hear good and 'not so good' news and we saw review notes had been amended to include a section about things which had not gone so well. One family member told us, "We've been sent questionnaires; I think they do take on board suggestions."

We received positive feedback from families. They told us, "The service is run well, with an exceptional management team and staff" and "There is a very happy and calm atmosphere in the home, the staff love the service users and enjoy looking after them. There is always a focus on the autonomy of the service users, as far as this is possible. The staff speak to and about the service users with respect and affection."

There was strong leadership from a registered manager with a passion for developing a person-centred service. A more senior, existing manager had become the registered manager since our last inspection which demonstrated the value place on the role within the wider organisation. The manager told us there was now improved oversight of the service. In addition, they were also the safeguarding lead for the organisation and it was felt this change would ensure people's safety was prioritised.

The service was continually striving to improve and learn. Prior to our last inspection, there had been a serious incident which had led to a review of the support to people who were at risk of choking. The manager had responded in an innovative and proactive way and as a result people were now more safely supported. The wide-ranging review had resulted in new policies, revised care planning and guidance which we saw working well in practice when we visited people. The new approach had been developed with input from a wide cross section of stakeholders, such as dieticians, caterers and other health professionals. As well as detailed information, the guidance offered practical advice to people and staff, such as example recipes and pictures showing what to do in an emergency if a person was choking.

Staff knew what to look for when supporting a person to eat to minimise the risk of them choking showed us

the changes in care plans and. audits now had a detailed review of arrangements to prevent choking; for example, staff had been required to review support for a person who was on a pureed diet but still having medicines in tablet form. Staff had contacted the GP as a result, to ascertain if medicine in tablet form was still appropriate for the person.

Sharing of good practice was a theme across the service and a team leader had written in a report on an observation in a neighbouring scheme, "I observed [named person] answered the landline phone several times. This was very positive to see and something I would like to implemented in my own services."

The registered manager was supported by an effective central support system and management structure. Front line staff and managers knew what their roles and responsibilities were. The manager was aware which schemes were geographically isolated and told us how they had brought a team leader across to another scheme to minimise isolation. There was a shared passion for the people they supported. A senior manager told us, "To tell you the truth I have never worked for an organisation that treats people with so much respect."

Local managers were able to make changes, so for example at one scheme we highlighted that information was being completed twice and the scheme manager immediately revised the processes so they became more streamlined. The registered manager expected care to be provided to a required level, despite the size of the organisation, however individual schemes had slight variations. This meant the service remained manageable and was flexible enough to respond to specific circumstances. For example, the largest scheme ran a system of 'support cards' to organise support, which was not appropriate in the smaller schemes.

Staff told us the service was well organised and they enjoyed working for the organisation. There was a series of staff incentives and staff were encouraged to work across the organisation to share new ideas and reduce isolation. Staff said the management had visible presence in the daily running of the service, although given the size of the organisation staff mainly had contact through local managers. Communication with staff was comprehensive, through the use of staff briefings, regular meetings and a newsletter. The manager told us they realised information could be overwhelming and led from the centre. This was being reviewed, for example since our last inspection the staff briefing had been revised to make it more attractive and relevant to front-line staff.

Feedback from professionals was positive. A health and social care professional told us, "Outlook have developed positive relationships with families, advocates, and other stakeholders." Another professional described a visit to one of the schemes. "It has always been a pleasure to meet with or visit this scheme where [staff] are passionate in their work. Purely from a personal point of view, if I had a family member who required the service, I would not hesitate for them to reside there and would have every peace and satisfaction that they were receiving an extremely high standard of care, dignity and respect."

We looked as support plans and saw the on-going communication between people and other professionals. This included working with professionals where people had complex needs, for example where a person was at risk in the community. A professional told us, "There is an agreed protocol between us, the placement and the police regarding what to do (to keep the person safe). I have been impressed with Outlook's work with this person to date."

The service also worked with other organisations to develop best practice. Two people who used the service had been involved in filming a video about what good communication meant to them and the experience of people with learning disabilities as they got older. This had been developed with an external organisation which had a focus on sharing best practice in the care sector. The service had also worked with a local

college to develop a bespoke leadership course.

There was a complex, yet highly efficient schedule of audits, which were planned to feed into each other so that learning from checks was on-going and risk was well managed. We were told how the schedules had been adjusted to ensure the board, responsible for deciding on areas of risk, had the necessary information to make an informed decision.

Quality checks were carried out by a wide range of staff, people and external representatives. For example, a former professional sat on the board and carried out regular audits of individual schemes. They told us, "Customers are confident in expressing their views and are encouraged by staff to do so." They said that in the past they had visited services but that now their role was more formalised and they received guidance about areas to look at. For example, if there has been an area of concern in a specific supporting living scheme they would focus on that during their visits. The board member told us they felt well communicated with and when they raised a concern about a person, they received a report about how this had been dealt with.

As well as on-going audits, the manager also arranged for 'themed audits' to happen to look at a specific issue, such as how the service supported people who did not have capacity to make a decision. The timetable of the themed audits was flexible. Following concerns raised about the quality of support plans, there had been a programme of audits in this area which took place alongside increased training and improved guidance to staff. The manager had circulated an anonymised version of a support plan, as a good practice example.

People who used the service were involved in the auditing of the care provided by the organisation. They were paid and received training in their role. The registered manager told us how they had supported a person when they carried out their first audit but now the person was able to take on this role independently. The person had received a detailed easy read report about their involvement, with the outcomes they had achieved and new targets for their next audit. The notes from the audit demonstrated people felt able to ask hard questions. The person had asked the manager how they knew staff arrived on time and had been shown the signing in book and told about unannounced visits by senior staff.

Information from quality checks was amalgamated, which enabled the manager to see where the highest level of risk was. Therefore, in our discussions with them, they could tell us which schemes needed most support and input, such as extra visits from an area manager or additional training for staff.

We saw from our observations and from audits that the quality of the housing was a frequent issue. As Outlook Care was usually not the landlord this presented a complex and challenging issue, outside of the remit of this report. We saw staff advocated for the people at the service and put measures in place to ensure they were safe. In one scheme, staff had supported people and their families to draft a letter of complaint to the landlord in relation to the disrepair in the property. Whilst waiting for the landlord to respond the care provider had paid for some alterations as they believed these posed a risk to people's health and safety.

Surveys had been carried out with staff, people and families and themes from the feedback, such as the need for improved communication with staff, were incorporated into improvement plans for the service. Surveys were in different formats based on a person's ability. For example, one person completed a written survey, whilst another had a survey based on 'happy' or 'sad' faces.

An advocacy group worked with people who found it hard to express themselves, using art and music

therapies to aid communication and find out how they felt about the service. Pictures and reports from this forum were then shared with the management team to ensure people's views were central to their decision making process. The report feedback stated that people liked the way the service was encouraging them to speak out. The report also said, "People were not very keen on the idea of the 'bosses' of Outlook coming to visit them in their house - they didn't feel they would be able to speak up openly in this situation. One suggestion that people liked was that residents could have a relaxed afternoon tea and invite the Outlook Senior Managers to meet them there." On the day of our inspection, we selected a scheme to visit and saw there was a pre-arranged afternoon tea taking place with senior managers, providing an opportunity for an informal meeting with people.

This was an example of outstanding practice, yet the manager was able to describe how they were still striving to improve on the current systems for measuring satisfaction. A campaign called, "Are you happy?" was being launched in 2017. We were told by the manager this aimed to "promote a culture where innovative customer satisfaction measures enabled the organisation to ensure it was working to its core values." A new tool had been developed to capture views about the service on an on-going basis and involved giving a person, family member, staff, or professional the opportunity to answer a set of questions using a smart phone. Accompanying picture cards have been developed which could be used to ensure people who needed support with communication could also answer the questions. This information would then be used for continual improvement. This campaign was being rolled out to staff and people during our visit and demonstrated the passion for innovation and improvement we had observed throughout the inspection.