A Chance for Life Limited

A chance for life Ltd

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection visit took place on 06 November 2017 and was announced.

A Chance for Life Ltd is a service for adults and children whose lives have been changed by injury or serious illness. The service provides case management and rehabilitation. It also provides personal care to people living in their own houses and flats in the community. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for people supported in their own homes; this inspection looked at people's personal care and support.
At the time of the visit there were 63 people who used the service.

At the last inspection in November 2014 the service was rated 'Good'. At this inspection we found the service remained 'Good'. Following this inspection in November 2017, we found the key question 'is the service effective?' to be outstanding.

The registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. Recruitment checks were carried out to ensure suitable people were employed to work at the service.

Staff skills knowledge, training and support demonstrated an excellent commitment to providing outstanding care which was embedded into the practices of the staff and the management team. The service put people's views at the forefront of the service and designed the service around their needs.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.
Risk assessments had been developed to minimise the potential risk of harm to people who used the service. These had been kept under review and were relevant to the care and support people required.

Care plans were in place detailing how people wished to be supported. People who received support, or where appropriate their relatives, were involved in decisions and consented to their care. People's independence and choice was promoted.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required.

We found people had been assisted to have access to healthcare professionals and their healthcare needs were met.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

The registered manager used a variety of methods to assess and monitor the quality of service provided to people. These included regular internal audits of the service, surveys and staff and relatives meetings to seek the views of people about the quality of care being provided.

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 remains good.

Is the service effective?

Outstanding ☆

This service had improved to outstanding

People their relatives and professionals were extremely positive about the service it offered to people.

Staff skills knowledge, training and support demonstrated an excellent commitment to providing outstanding care.

Staff and the management had an excellent understanding of the principles of MCA and DoLS and how to protect people from unlawful restrictions. It was clear people and where appropriate relatives and professionals had been included in decisions about their care and had agreed to it.

Training provided to staff fully equipped them to deliver exceptionally high quality care to people.

People had access to relevant professionals to support their individual and holistic needs.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

This service remains Good

Is the service well-led?

Good

This service remain Good.

A chance for life Ltd

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.

This inspection site visit took place on 06 November 2017 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is domiciliary care service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

We visited the office location on 06 November to see the manager and office staff; and to review care records and policies and procedures.
The inspection team consisted of one adult social care inspector, two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We also had a specialist professional advisor who was an occupational therapist specialising in mental health.

Before our inspection visit we reviewed the information we held on the service. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people who used the service. We also reviewed the Provider Information Return (PIR) we received prior to our inspection. 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. This provided us with information and numerical data about the operation of the service.

The inspection was also informed by feedback from questionnaires completed by a number of people using services. This complimented staff on the ability to provide consistent care demonstrating excellent skills and knowledge.

We contacted seven people who used the service, three relatives via telephone interviews. We also spoke to

two staff members face to face. In addition we emailed all staff who worked at the service and received feedback from 10 staff. We spoke with the clinical director, care coordinator, case managers, the business manager and the registered manager.

We looked at care records of five people who used the service, training and four recruitment records of staff members and records relating to the management of the service. We also contacted the safeguarding department at the local authority.

Good

Is the service safe?

Our findings

People told us they felt safe using the service because they trusted the staff that supported them. Comments from individuals who used the service included, "Yes I feel absolutely safe. We have a great team of carers. I would speak to our case manager if I had any concerns."; "I'm absolutely safe with them. It just works for us." People, relatives and staff had good working relationships which enabled them to communicate honestly and without fear of repercussions and this was evident in our discussions with people. One relative said, "Yes, [my relative] is definitely safe. I would speak to the manager, if not."

Risks to people were assessed and their safety was monitored and managed so they were supported to stay safe and their freedom respected. The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. Staff we spoke with demonstrated a positive risk taking approach which was underpinned by a desire to ensure people's freedom was not limited due to risks around them. One staff member told us; "Throughout my time working in ACFL; I am most proud of how we as a team have supported our clients with very complex physical health needs to fulfil lifetime challenges and special experiences. This includes holidays abroad with support staff and specialist equipment, outdoor activities such as abseiling in a wheelchair and supporting clients into work."

The registered manager had procedures in place to minimise the potential risk of abuse or unsafe care. These had been reviewed since the last inspection and training continued to be updated for staff. In addition staff had been recruited safely, appropriately trained and supported by the management team and clinical team.

Care plans seen had risk assessments completed to identify the potential risk of accidents and harm to staff and the people in their care. The risk assessments we saw provided instructions for staff members when delivering their support. Where potential risks had been identified the action taken by the service had been recorded. We reviewed how a safeguarding incident which had occurred in the service was dealt with. We found safeguarding procedures carried out and protection measures were robust and took into consideration wishes and feelings of people and their relatives.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit staffing levels were observed to be sufficient to meet the needs of people who were using at the service. Comments from people demonstrated that the provider had ensured that people had the right number of staff to support them. Comments from relatives included, "Yes, I would say they employ enough staff to provide [my relative] with consistent care." Another person said; "Yes, their timekeeping is very good. They have never let us down."

Comments from staff included, "Support staff rotas are tailored to each individual's needs and we employ staff specifically for each person." The registered manager informed us that the staffing arrangements allowed them to bring in additional care staff as required and in response to the needs of the people in their care at any given time. This would ensure that people's needs would be met in a timely manner.

We looked at how medicines were recorded and administered. Staff had ensured that people's medicines were managed safely. Not all people who used the service required support with medicines however, risk assessments had been undertaken to ensure that those who managed independently did so safely. The relatives we spoke with told us they were happy with the support provided to people to receive their medicines. We looked at medication administration records for two people. Records showed medicines had been signed for. The registered manager had internal audits in place to monitor medicines procedures.

Evidence we saw showed that lessons were learnt and improvements were made when things went wrong. For example where people's expectations had not been fully met and where errors such as medicines errors had occurred. Staff had received supervision and discussed ways to improve their practices.

Policies and practices in the service ensured people were protected by the prevention and control of infection. For example staff had received induction and training on infection control and prevention. Staff who supported people with food preparation had received food and hygiene training. This helped to ensure people would be protected from risks of infections.

Outstanding ☆

Is the service effective?

Our findings

We received extremely high praise from people and relatives about the knowledge, expertise, skills and caring approach from the staff. People received effective care because they were supported by a staff team that were exceptionally co-ordinated. Staff were very experienced in supporting people living with acquired brain injury and had experienced traumatic physical injuries. Comments from people included; "They have helped me to set goals I work towards. They have given me targets for cooking food and I've done that. They've helped me pass my driving test."; "The staff are all brilliant and very well trained." And; "Yes they are excellent and very professional."

All staff we spoke with told us they knew the people who used the service well because it was a small service and the service they provided was specialised and tailored to each individual's needs. A case manager told us; "We have time to get to know our clients as we can generally take as long as we need in sessions and see them as frequently as we feel is required as we have small caseloads."

Professionals provided excellent feedback about the staff skills and the experiences of people. One professional said; "From my experience the staff have always been involved in/contributed to multidisciplinary meetings, they have shown professionalism and recent experience has indicated staff have good working relationships and rapport with service users." Another professional told us, the "Staff are well trained and very well supported by a dedicated management team who are passionate about their work." It was abundantly clear that the service had sustained and improved the standards identified at the last inspection and the outstanding rating achieved.

The staff team comprised of highly skilled and experience multidisciplinary clinical professionals and support workers. The case managers were professionals such as occupational therapists, physiotherapists and nurses. Support workers had vocational qualifications in health and social care as well as extensive experience in acquired brain injury. In addition there was an extensive training programme in place that supported and underpinned the excellent knowledge and skills of the staff team. This was enhanced with specialist training that supported the diverse needs of people supported by the service.

This service had an innovative and creative training programme which was embedded in the values of staff and was evident in their performance, providing high quality care. There was a focus on delivering training to all staff regardless of their role using creative methods such as scenarios to develop learning and understanding which related to people's specific needs. The model of care approach was designed to deliver a truly person centred service. For example, before a care package was accepted, staff were recruited, followed by a comprehensive assessment of the person's needs. Once the needs had been identified, the staff team's training needs were assessed and bespoke training was provided in line with the person's needs. This was over and above the mandatory training provided to all staff in the organisation.

There were a variety of learning and development pathways in the service. For example there was face to face training, e-learning, regular group clinical case discussions and supervisions. The organisations had utilised innovative methods to deliver training using latest technology such as video conferencing. This had

been used to access training from training providers who would not have been easily accessible to the service due to distance. In addition there was specialised training provided to clinical and support staff including training such as, 'navigating the mind field: mild traumatic brain injury platforms, and meeting the challenge in neurological physiotherapy practice.' We also found service managers were given flexibility to assess training needs for their own teams and to autonomously arrange training in their localities to avoid the long wait for training arranged at the head office.

Staff told us the training and support they received had given them the skills, knowledge and confidence they needed to carry out their duties and responsibilities effectively. We spoke to five case managers who told us the organisation takes pride in their staff's development. Comments from case managers included, "Staff would never work with a client unless they had the correct level of training, experience, knowledge and were competent." And "We all (clinical and support staff) receive appropriate training and can always ask for more training as required. Clinical staff have a yearly budget set so everyone has equality on the level of training they receive. Staff are encouraged to look at new training opportunities and are supported to maintain up to date continuous professional development. (CPD)." A support worker told us; "They have supported me through my training and to progress and complete level 2 and 3 NVQ"

The design of the service and practices demonstrated exceptional efforts and ethos to provide co-ordinated and a collaborated service. A case worker told us; "If we work with a client who is challenging we work with the psychologist working with that client to understand the underlying issues and how best to support and manage them. As a case manager I would also make sure that any support workers get time with the psychologist to learn about this directly from them." The records we looked at showed evidence of various conversations and referrals made to local authorities and other statutory services on behalf of people. Case managers arranged multi-disciplinary meetings with agencies such as children services and adult services. This demonstrated that staff teams within and across the organisation worked together to deliver effective care, support and treatment.

Staff also told us that they received regular supervision from the clinical director; who supervised the clinical staff and case managers or a care co-ordinator in the case of support workers. Staff added that they could approach their managers for support whenever they needed them. We saw that during each supervision case managers were assessed against the British Association of Brain Injury Case Managers (BABICM) competencies. There are seven competencies that include; communication, strategy, co-ordination and management, monitoring, duty of care, professionalism, and personal attributes.

The case managers used their expertise and experience to train other people who worked with the people they supported. This included staff who were not linked to the service such as schools. One relative told us, "The occupational therapist has gone into school and provided training for the school that is way above what she needs to do." This was an example of sharing best practice and expertise to meet the person's needs in a holistic manner.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedure for people living in their own homes is called the Court of Protection authorisation. The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Care records showed staff sought people's consent before the service was provided. We saw clinical staff had sought consent from people before each clinical intervention and clearly recorded whether people could consent to the intervention.

Staff and the management demonstrated an exceptional understanding of the principles of the MCA and the Court of Protection and how it related to protecting people from unlawful restrictions. Feedback from the registered manager and all staff confirmed they understood when people lacked capacity and the actions to take to support them. We saw information and latest research on mental capacity in the practice area of brain injury was shared with staff in the staff newsletter.

Feedback from care staff demonstrated mental capacity was embedded in their day to day practices. One case manager told us; "When our client's lack mental capacity they usually have a court appointed deputy (or advocate) to manage their affairs. We regularly liaise with this professional/s on the client's needs and when there are any decisions to be made about their care, accommodation or education there would be a best interest meeting with the client's full team. Our clients may not be able to be a part of this process as it may be deemed not in their best interests but they will always be informed and their views taken into consideration." Care files demonstrated a thorough approach that ensured people or relevant relatives and professionals who acted on their behalf were involved in and agreed to the care delivered.

Care files were clear in their guidance to support the staff to meet the individual nutritional needs of people. Staff had clearly identified people who required support with their nutritional needs through the initial assessment. Files had evidence that a comprehensive nutritional risk assessment had been completed that identified what support people required. Where specialist nutritional support had been identified for example; where there was a risk of choking, care plans and risk assessments had been developed. These were thorough and contained detailed guidance to support staff in providing safe care whilst minimising any risks. Records confirming intake of food and fluid were detailed and comprehensive and where changes in intakes occurred these were easily identifiable for staff to respond to.

We found the registered provider had a proactive approach to meeting people's needs especially where people had complex dietary needs. For example we found they were in the process of assessing an individual who required alternative ways to support their nutritional intake. These included nutrition via a percutaneous endoscopic gastrostomy tube PEG tube. In order to ensure the person would receive the right level nutritional support, the provider was in the process of recruiting a nurse case manager who specialised in this area. This was evidence of proactive and forward planning to ensure the smooth delivery of personalised care.

The staff team used their expertise to ensure that people's individual needs were met by the adaptation, design and decoration of their properties. There was a team of occupational therapists who undertook environmental adaptation assessments and made recommendations Care records showed comprehensive assessment had been carried out by the occupational therapist to ensure people's environments were appropriately adapted to safely meet people's needs. For example one person required adaptation to allow access to the property and to bathing facilities. This had been provided as a comprehensive package which demonstrated a holistic approach to care delivery.

We looked at how people were supported to live healthier lives, have access to healthcare services and receive on going healthcare support. The service had links with other healthcare professionals, which was recorded in people's intervention and treatment plans. There was also clear evidence of the service seeking advice and support from other agencies and we saw that guidance from healthcare professionals had been incorporated in people's care plans. For example, we saw that one person had complex needs. There was detailed analysis of their needs with the required interventions to include behavioural optometrist, psychologist and orthopaedic. There was guidance and contact details for specialist professionals to ensure people received seamless care.

Records confirmed that people's health needs were frequently monitored and discussed with them. They demonstrated that people had received input from health professionals such as their neuro-physiotherapist neuropsychologist, dietician and speech and language therapist. In addition the service used its own clinical professionals to provide support where required for example physiotherapy and occupational therapy services.

Good

Is the service caring?

Our findings

The service had a positive and caring culture which people, relatives and staff supported and promoted. People told us they were consistently well supported and well cared for. Comments from people included, "Yes all of them are kind and caring no problems at all with the staff.", and "Yes the staff are all lovely people as far as I can see." Another person told us, "The (occupational therapist) was just the person I was given, but I'm actually really happy with them." A relative said, "They do respect her privacy when helping her wash and dress." Another relative said, "They always take our opinion on board and we are included in everything."

All of the relatives we spoke with told us they trusted the staff and the service in general with the care of their relatives. They commented that their family members had made significant progress whilst being supported by the service and their lives, as well as their family member's lives, had been transformed.

There was a very strong person-centred culture at all levels and staff understood that people were at the heart of the service. This was because the registered manager and staff promoted a consistently caring culture based on a range of clear policies and procedures they had in place. Staff had a good understanding of protecting and respecting people's human rights. They had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was an extremely sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society. For example all staff were trained to advocate for people to ensure they had equal access to statutory services.

Through our discussions with people we noted that arrangements had been made to meet their personal wants and diverse needs. From the information contained in their support records; we saw people were fully enabled to develop and maintain their personal relationships with their circle of support. One person who was supported by the service told us how their self-esteem had increased greatly through the care they had received saying, "I couldn't live the life I wanted, and now with all the fantastic support I get I am absolutely loving life and everything about me is different, they [support staff] have literally given me a new life."

Staff and their registered manager were highly motivated and reflected pride in their work. They talked about people in a way which demonstrated they were fully committed to supporting people in any way they could, in order for them to achieve as much independence as possible. Staff sought to provide the best standards of care for each individual. One member of staff said, "We are all empathetic towards our clients, working in the field of brain injury is something I feel we do well as we have the compassion and want to help people get the right support and therapy to help them to achieve their goals. A lot of us have some personal experience with family/friends and I feel this helps us gain an understanding of what life is like for our clients and their families, the challenges that they face and how we can best support them."

Staff explained how they promoted independence, by enabling people to do things for themselves. One staff member said, "We put extreme efforts in ensuring people can regain their independent living skills to do as

much as they can. We have worked with one person to learn how to travel independently using public transport and to use the gym and cook their own meals." Care records comprehensively outlined the goals and outcomes that people wanted to achieve what support they needed.

There was evidence of how the provider had engaged with people during the design and delivery of care. For example the registered manager told us, "All our clients have their own dedicated support staff. When we are recruiting staff, we ask the client and their families if they would like to be involved in the recruitment process so that we represent their choices and preferences accurately. For example the client can design interview questions which cover particular issues of importance for them."
In addition staff made sure they gave information to people, their families and other carers about external bodies, community organisations and advocacy services that could provide independent support and advice. This included organisations that could answer questions about their care, treatment and support, and, where necessary, advocate for them. For example people were signposted to 'Headway'. Headway is a charity that works to improve life after brain injury by providing information, support, events, activities and opportunities locally.

Care files demonstrated a thorough approach that ensured people or relevant relatives and professionals who acted on their behalf were involved in and agreed to the care delivered. Information relating to how to access advocacy services was available. This ensured people were supported to make safe decisions. Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. It defends and safeguards their rights. The ethos and design of the service meant that case managers worked as clinical professionals as well as advocates in all instances to ensure people had access to statutory services. We saw evidence of letters written by case managers to the local authorities on behalf of people asking for statutory assessments such as social work intervention.

Good

Is the service responsive?

Our findings

People received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. Comments from people included; "The staff have been good. They've gone above with my daughter. My case manager had to be quite creative to speak to me. She's been very responsive and been there when required but backed off when needed."

People's care records demonstrated that the service had ensured that people's care plans fully reflected their physical, mental, emotional and social needs. They had been developed where possible with each person, family and professionals involved with them, identifying what support they required. Relatives told us they had been consulted about support that was provided before using the service. They told us they sat down with case managers and the registered manager regularly to discuss what had gone well and what could be improved. One person told us; "We are actually working on the care plan at the moment." A relative told us, "Yes, the care plan is reviewed all the time because [relative's] needs change." Another relative said "Yes, I always have quarterly meetings to discuss future goals."

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified, for example, people who required assistance with moving, neurological needs, people who were at risk of choking and people who were at risk due to their vulnerability. We also found case managers completed separate clinical needs assessments which identified any therapeutic interventions needed. For example speech and language therapy intervention and physiotherapy.

There were personalised assessments of accommodation which identified any shortfalls to provisions and identified specific medical equipment or adaptations required. Clinical assessments and recommendations were clearly supported by outcome measures. This helped commissioners of the service and people to understand the benefits of the recommended interventions.

Staff were recruited to work for each specific individual. Before employment commenced staff received training that was specific to the person's needs which meant they got to know and understand the people they provided care for. In addition people who used the service and their representatives interviewed the care staff themselves to check if they had the right skill and ethos to meet their needs. Staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care and rehabilitation records. This meant that staff had an understanding of people's needs and wishes, but also of their strengths and abilities.

Staff had supported people to acquire statutory services to meet their needs and in some instances they had recommended private services where statutory services were not available. People and their relative were provided with relevant information relating to the services recommended including the qualifications, history and experience of the recommended clinical professionals or agencies.

The registered manager and the clinical director explained to us that when written instructions are received by the service for a new care package, a case manager will make the initial assessment. Following the completion of the assessment a case management proposal will be written up and sent to the instructing person for their or their client's approval. The case management proposal identifies the person's needs and recommends interventions to meet them. This is also used to identify the skills and experience needed by the staff who will be employed to care for them. Each person had a set of goals with target timeframes in which to achieve these. These were reviewed regularly by case managers. Monthly summary reports were completed which reviewed people's goals and outline people's on-going progress. All the care records we reviewed and case supervision records confirmed this.

People were supported to maintain local connections and important relationships. People were also actively encouraged and supported to maintain local community links. For example, we saw one person who used the service had been supported to regularly maintain contact with their local community using public transport and to continue accessing facilities in the community. The service had also worked with a local outdoor activity provider. Although they were not using the service at the time of the inspection, people's records showed that they took part in hikes, rock climbing and other outdoor adventures. This helped to maintain continuity and reduce social exclusion for these individuals. A case worker told us "Each client is supported to take part in activities culturally and socially relevant to them should that be their wish. Activities and community involvement are discussed and planned with client, family and support staff. Education and vocational opportunities are looked at on an individual basis, where there may be no current input or need for transition options are explored with each individual and their team."

Another case manager told us "When drawing up our support plans we look at interests and options and build that into the plan so that support workers can enable participation in activities that the client enjoys. As occupational therapists we often complete an interest checklist with our clients to find out what they have done in the past, what they would like to do now and in the future. We also work on vocational and educational goals with some of our clients who have aspirations in those areas."

The service had a complaints procedure which was made available to people and their representatives before they started to use the service. Copies were on view in the office and in the care files we reviewed. The complaints procedures had been written in an easy read format to enable people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

We spoke with people who used the service and with relatives. They told us they knew how to make a complaint if they were unhappy. They told us they would speak with the registered manager or their case managers who they knew would listen to them. No complaints had been received at the time of our inspection.

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example there was a policy which guided staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Good

Is the service well-led?

Our findings

We received positive comments from people about the organisation. Comments included; "Yes I would say the company is well managed and the team is great.", "The management are helpful if we need to contact them about anything" and "Yes the service is well managed, it is just nice to get some help. It is a massive help for us to get help from people who know what they are doing."

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide good quality care. Comments included, "I think as a clinical team we support each other well, we have regular occupational therapist and clinical management meetings (quarterly) and twice yearly full team meetings where we also carry out peer supervisions and share good practice. When issues arise in support teams staff and the registered manager work well to resolve any conflict collaboratively and quickly." Also, "My line-manager is always supportive and caring. I feel very valued by her and feel that I can say anything and she will help me find a better way to deal with any frustrations or things that need to change."

Staff we talked with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager was experienced occupational therapist by profession with an extensive health and social care background. They had worked at the service for a long time. They were, knowledgeable and familiar with the needs of the people they supported. In addition to the registered manager, there was a clinical director, who had a clinical background in physiotherapy in acute in-patient care and in-patient rehabilitation units as well as community rehabilitation. The clinical director and the registered manager also held cases and worked in the community. This helped to ensure they understood the challenges that staff faced. They supported a team of 13 case managers, a business development manager, support workers and office staff.

All staff had delegated roles including case management, clinical oversight, office administration and care delivery. Each person took responsibility for their role and had been provided with oversight by the registered manager who was also the nominated individual.

Staff and service user meetings were held on a regular basis. We confirmed this by looking at minutes taken of meetings and care files. In addition staff and 'relative/family' surveys were carried out regularly. The registered manager analysed any comments and shared them with registered provider who had acted upon them. The feedback we saw demonstrated people felt the service was of a good quality. We saw people and staff were consulted on the daily running of the service and any future plans. The registered manager regularly held meetings with all case managers to discuss any clinical developments and the future of the service. One case manager informed us; "Visions and values of the service are formally shared with us at meeting held twice a year and also informally through conversations and the newsletters. We have always been trusted to do things our own way, using our clinical judgement in the best interest of our clients."

We saw initiatives by the registered manager to demonstrate how they cared for their workforce. For

example, in their PIR they told us; 'We are currently working towards the Better Health at Work Award Scheme, Bronze Level. This is aimed at improving the health, safety and wellbeing of the workforce and involves looking at health training, work based health interventions, policies and our culture around wellbeing at work. Three of our employees are nominated health advocates and regularly communicate with staff with campaigns, posters, displays and information.' Our conversations with staff confirmed this.

The registered manager and provider had auditing systems to assess quality assurance and the maintenance of people's wellbeing. We found regular audits had been completed. These included medicines, the environment, care records, accidents and incidents and infection control. Any issues found on audits were quickly acted upon and lessons learnt to improve the care the service provided.

The provider had undertaken quality assurance inspections in the service. These audits provided support with ensuring compliance and analysing information in the service such as accidents and incidents. It included monitoring that the service was complying with regulations and quality requirements with other regulatory authorities. They also drew up action plans for the registered manager and monitored that these had been completed in a timely manner. The registered manager met with the clinical director on a monthly basis to discuss the quality of the service, progress and future plans. This also gave them the opportunity to discuss areas of concern and to share updates in requirements or any developments or changes in regulatory requirements.

We saw evidence to demonstrate that the service had adapted to keep up with best practice. This included using technology to train staff and to share information. These staff would attend multi-disciplinary meetings with other stakeholders such as the local Clinical Commissioning Groups children service departments and adult social care services within the local authorities. They also shared information and best practice with other charitable organisations such as Headway.

There were strong links with the local community and the service had strengthened their relationships beyond the key organisations. We also found there were arrangements to ensure the service and staff kept up to date with good practice.

In their PIR the registered manager wrote; 'We have memberships of professional bodies such as The Royal College of Occupational Therapy, the Nursing and Midwifery Council, The Chartered Society of Physiotherapy, and all our clinical staff are registered with HCPC (Health Care Professionals Council). All case managers are members of the British Association of Brain Injury Case Managers (BABICM) and the Case Management Society (CMSUK). The company is a corporate member of Headway, the national charity for brain injury and individual staff are involved with regional Headway groups. We are also members of The Northern Acquired Brain Injury Forum (NABIF) and Cumbria Neurological Alliance. Staff attend regular training courses (both external and internal) and also attend conferences and exhibitions, many of which are accredited with continuous professional development (CPD) points.'