Westminster Homecare Limited

# Westminster Homecare Limited (t/a Independent Living Network)

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 25 and 26 November 2015 and was unannounced. This was the first inspection of this service at this registered address.

Westminster Homecare Limited (t/a Independent Living Network) is a domiciliary care and supported living service that is registered to provide personal care to people living in their own homes. A service is provided

# Summary of findings

mainly for people living with a learning disability. At the time of our inspection there were 140 people using the service. In supported living services, people live in their own home usually under a tenancy or licence agreement. They often receive personal care and/or social support in order to promote their independence.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a new manager but they had not yet taken up their position.

A process was in place that helped ensure that staff were recruited after all the required checks had been completed. Only those who were staff deemed suitable to work with people using the service were offered employment. People were cared for by a sufficient number of suitably qualified staff.

Staff had been trained in medicines administration. They had their competency to do this regularly assessed. Safe medicines administration practice was adhered to.

Staff were knowledgeable about, and had regular training and updates in, protecting people from harm. Staff knew who they could report any concerns to including their manager, the local safe guarding authority or the Care Quality Commission.

The operations' manager and staff were knowledgeable about the situations where an assessment of people's mental capacity was required. The service was working within the principles of the Mental Capacity Act 2005. Applications were being processed through the local authority to lawfully and safely deprive some people of their liberty.

People were supported with their care needs in a way that respected their privacy, dignity and independence. Risk assessments were in place for subjects such as supporting people out in the community, behaviours which could challenge others and medicines administration. Checks were completed to help ensure that people's homes were a safe place for staff to work in.

A formal assessment process was in place to help ensure that people received the care they wanted. People were involved in this process in defining and agreeing their care needs.

People were supported to see or be seen by a range of health care professionals including their GP, community nurse or psychiatrist.

Sufficient quantities of food and drink were made available for people. People could choose to be as independent as they wanted with their eating and drinking.

Staff were provided with regular support, mentoring and training for their roles. This was through an effective programme of planned supervision and appraisals.

People were provided with information, guidance and support on how to report any concerns, compliments or suggestions for improvement. However, there was no alternative formats provided to people such as easy read documents. The provider took appropriate action to ensure any complaints were addressed to the complainant's satisfaction.

Audit and quality assurance procedures were in place. However, not all audits were effective. The provider had not always notified the CQC of events that they are required, by law, to do so.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

Staff had training and competency assessments to help ensure people were safely supported with their medications. Staff were knowledgeable and confident about the correct reporting procedures and how to keep people safe from harm.

People's needs were met by a sufficient number of suitably qualified staff.

The provider's recruitment process helped ensure that only suitable staff were offered employment with the service.

Good

**Is the service effective?**
The service was effective.

People were supported to make and be involved in the decisions about their care. Staff supported people who shared common interests with hobbies and interests where this was possible.

People were supported to eat and drink sufficient quantities of the foods they preferred. People were encouraged to eat healthily.

Staff supported people to access health care professionals when required.

Good

**Is the service caring?**
The service was caring.

People were cared for by staff who showed dignity, compassion and an understanding for their preferences.

Staff encouraged people to make their own choices about things that were important to them and to help them maintain their independence.

People's care needs and the subjects that were important to them were considered and acted upon. People were made to feel they really mattered.

Good

**Is the service responsive?**
The service was responsive.

A detailed assessment of people's individual needs was undertaken before they used the service. People and those acting on their behalf were involved in the assessment and planning of their care.

People were supported to actively follow a wide variety of their hobbies, interests and pastimes.

Complaints, concerns, suggestions and compliments were used as a way of recognising what worked well and what did not work quite so well.

Good

# Summary of findings

**Is the service well-led?**

The service was not always well-led.

The provider had not always notified us about events they are required, by law, to do so. This meant that the provider had not met the legal responsibilities.

Audits and systems to measure the quality of the service were not always as effective as they should have been.

The manager of the service had developed and fostered an open and honest culture with all their staff.

**Requires improvement** 

# Westminster Homecare Limited (t/a Independent Living Network)

**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 took place on 25 and 26 November 2015 and was unannounced. The inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we visited and spoke with five people in their homes and spoke with three people and six relatives by telephone. We also spoke with the registered provider's operations manager, two project coordinators, six care staff and administration staff. We also spoke with the local authority's Learning Disability Partnership (LDP) and contract monitoring teams.

We looked at five people's care records, managers' and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's health and safety. We also looked at staff recruitment, supervision and appraisal process records, training records, compliments, quality assurance and audit records.

Good

# Is the service safe?

## Our findings

People who used the service, and their relatives, told us that they were supported with their care needs at the times they had requested. One person said, "They [care staff] have supported me for years and staff always turn up. They [care coordinators] always ring if they [staff] are going to be late due to traffic." Another person told us, "I couldn't ask for a better team. I can't wait for them to arrive. I have no qualms whatsoever about my care staff." Another person said, "I can't do much without them [staff] they are here for me and help me to go outside safely." A relative said, "I feel [family member] is safe as the staff know them so well. They talk nicely and are so careful dressing and washing them." We observed that staff were aware of people's needs and how to ensure that the support and care provided was safe. People and relatives told us that the office based staff contacted them if any staff were delayed or were to be replaced for any reason.

Records viewed and staff we spoke with confirmed that staff had undertaken training as to how to protect people from any harm or risk of harm. Staff demonstrated to us their knowledge about abuse and how to identify and report any suspicions of harm or poor care practice. They gave examples of the different types of harm and what action they would take to report such incidents. Staff were aware of the external agencies such as the local authority and the Care Quality Commission that they could also report any concerns to. This showed us that there were processes in place to reduce the risk of abuse.

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said they would "definitely" have no hesitation in reporting unacceptable care. Another member of care staff said, "I feel very confident that [name of manager] would take swift action to protect me and the person I care for. They would always support me."

Risk assessments were in place for subjects including those for people with behaviours which challenged others, people at risk of malnutrition and being out in the community. These risk assessments were reviewed regularly to ensure that people were supported to be as safe as practicable. Detailed information about the risks each person presented and what the control measures were, was available to staff. For example, for people's behaviours what the triggers were and what calming measures worked best for each known situation. One member of care staff said, "Every day can be so different but when [name of person] exhibits challenging behaviours I know what to do and what normally works." Other risk assessments included checks that were completed to help ensure that people's homes were a safe place for staff to work in. This was to assist staff in accessing the utility power supply isolation points, as well as the secure storage of people's medicines.

During our inspection we found that and people and relatives confirmed that there were sufficient numbers of staff to meet people's assessed care needs. We also saw at people's homes we visited that there was sufficient staff to meet people's needs. One person said, "They [care staff] are here every day. I have never had a time when they haven't turned up." One relative told us, "My [family member] is much safer now. They have more or less the same staff and this has made a big difference at putting them at ease again." The operations manager told us, "We are recruiting more staff. It is an ongoing task due to recent staff turnover." They informed us that where the provider was not able to safely support people safely that they would not continue with people's care. We found that this was the case. One person said, "They [care staff] stay for the right time. They make sure I have everything I need."

Arrangements were in in place for unplanned absences such as staff calling in sick. Care and management staff told us that permanent staff covered extra shifts. They added that agency staff had been used but that this was a rare occurrence. Management staff also carried out care visits to help cover staff absences.

Accidents and incidents such as when people had experienced a fall, there were medicines administration errors or challenging behaviour episodes, were recorded. Care staff discussed specific triggers for people's behaviours, such as when going out in a wheelchair or going to specific places such as the GP or certain shops. We found that staff knew what calming measures worked for the person. We saw that actions had been taken to prevent the potential for any recurrences. This included liaison with the person's GP for alternative medication options as well working with the LDP where changes to, and with, people's care had been identified.

Staff told us that before they were offered employment they had to produce various documents and records.

Good

# Is the service safe?

Examples of these included a full employment history, two written employment references, undergoing a check for any unacceptable criminal offences, photographic identity and proof of eligibility to work in their United Kingdom. These checks were completed before staff commenced their employment. This was to ensure that staff were only employed when they were deemed to be suitable to look after people. One relative said, “I have never had any concerns about any of them [care staff]. I would soon call the office in Ely if I had any concerns.”

People were supported to take their medicines in a safe way which included people with allergies to certain medicines. Each person’s medicines administration records (MAR) contained the level of support, dosage and timings specified by the prescriber. Records and staff confirmed that they had been trained and assessed as being competent in the safe administration of medicines. Staff were able to tell us about the requirements to support people with their medicines, which also required medicines to be administered straight away. Medicines were recorded accurately and were stored and secured appropriately in people’s homes. One person said, “They [care staff] don’t need to help me take my medicines but they remind me and write down when I take them."

Good

# Is the service effective?

## Our findings

We found, that people were supported by care staff who knew people and their support needs well. One member of the management staff told us about the people we visited and they knew each person's likes, dislikes and day to day care preferences.

Staff told us about their induction and said that it enabled them to do their jobs effectively with support from more experienced staff and managers. One member of staff said, "My induction [training] covered several subjects including moving and handling." All staff spoken with had received training in subjects such as the administration of medication, fire safety, food hygiene, infection control and the Mental Capacity Act 2005 (MCA). One member of staff said, "We have lots of training and feel really well supported. There is always a senior member of staff to talk with if we have any concerns."

Training records and information we looked at confirmed staff were supported to receive training specific to the roles they were employed in. Other mandatory training for care staff was planned and provided regularly with updates scheduled for staff. Staff were only retained where they showed that they possessed all the required skills and abilities to work with people using the service. This covered subjects such as, supporting people who had behaviours which could challenge others, epilepsy and looking after people living with dementia. Staff told us and records also showed that staff were supported to undertake nationally recognised qualifications, which included the Care Certificate.

People were supported by staff who had known them for a long time as well as new staff being mentored in getting to know people better. Staff told us that they could work in more than one of the supported living schemes and homes where people lived. This was so that they had the opportunity to develop a broad understanding of what each person's care needs were. We saw and found that staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. We checked whether the service was working within the principles of the MCA. Appropriate applications were being progressed by the local authority to the Court of Protection.

We found that the operations' manager, senior staff and care staff had an understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests. Where people did not have the capacity to consent, the provider understood their responsibilities in relation to the MCA. For example, the operations' manager and management staff confirmed they were working closely with the local authority to lawfully deprive some people of their liberty so they could be supported safely.

We saw that each specific decision a person could make had been determined and what information the person could retain. Where care was in the person's best interests this was documented. Decisions that had been made in the person's best interests had been determined using information from families, GPs, staff and the registered manager. Staff knew when to respect people's choices. This showed us that staff knew what protection the MCA offered people and also to staff.

People were enabled to choose their preferred meal options. We saw that people were supported to ensure they ate and drank sufficient quantities. This included the foods people liked, how and where they liked to eat them and any particular dietary needs. One relative said, "My [family member] is so much better and healthier now. They have put weight on and now eats very well." We saw and staff confirmed their understanding of each person's nutritional needs.

Care staff told us, and we found, that they supported people to access health care professionals including a GP, chiropodist, or dentist when needed. Records we looked at confirmed this. One person said, "I have [a health

Good

# Is the service effective?

condition] and the staff make sure I attend my appointments on time and also that I am well afterwards." Another person said, "I have [name of health condition] and the staff encourage me to do things such as swimming which really helps my [health condition]. A relative said, "They [care staff] are very good. In fact, the other day when I was out they called a GP and told me they had done this for [family member]." The management and care staff confirmed when referrals to health care professionals had been made, for example psychiatrists and how these were followed up. This showed us that people's healthcare needs were responded to.

Good

# Is the service caring?

## Our findings

Staff respected people's privacy and dignity and spoke with them in a way that was respectful and compassionate. One person said, "Staff are excellent, polite and trustworthy. I wouldn't go with anyone [care provider] else." Another person said, "The girls [care staff] always talk to me in a dignified way and never discuss anyone else's care. I can't fault them in any way." People confirmed that staff always knocked on their room or house door, introduced themselves and gained permission before entering the house. One person said, "I mainly get the same staff and I can have a male or female carer." The person confirmed that their preference was always respected. We saw one person welcomed the manager and showed how well they liked them. A relative told us, "I have also needed some support recently and they [managers] have been there for me too."

We saw and found that staff were matched, as far as possible, with the people they cared for. Examples included people who had a preference for the gender of their care staff as well as staff who got on well with the person. We saw that staff responded to people needs, as well as those who were not able to communicate in a verbal way, in recognition of what the person was communicating. For example, by the person pointing to an object of reference or staff recognising what the person was referring to, or by the person's behaviours or body language. One person said, "I am an easy going person and the staff that support me are the same. We get on really well." There was much conversation and laughter between care staff and the person they cared for. It was obvious by staff interactions that the staff wanted to be, and enjoyed being, with people. The staff spoke of people's achievements, pointing out what they could do and spoke with them about their lives and hobbies. Staff were attentive to people's requests for assistance and supported people using appropriate language, referring to people by their preferred name and talking politely and respectfully with people.

Care staff described and people we spoke with confirmed various methods they used to help support people with their privacy and dignity. This included enabling people to do the tasks they could do on their own. One relative told us, "Since [name of provider] started caring for [family member] they have come out of themselves. They are so much more independent now. The staff even tell me things I didn't know about [family member]." One member of care staff said of the person he was providing support to, "Such a pleasure to work with." Other examples staff used to engage with people included engaging in conversation with people and explaining each aspect of the person's care. This was to offer reassurance as well as respecting people's independence. One person said, "They [care staff] normally introduce any new staff with the existing ones."

People had their personal care provided in the room or place of their choice and were encouraged to be independent. One person said, "They [care staff] make sure I have a wash." People, their relatives and care staff confirmed that people were involved and enabled as much as possible in their care planning. This was also for those people who were not able to tell staff in a verbal manner what was important to them. One person said, "I had a visit from [name of manager] last week. I like them as they know me but listen to what I have to say." Another person told us that staff treated them kindly and they liked the staff. Care staff told us and we found that where people experienced a family bereavement they would support the person with their memories as well as being sympathetic to their situation.

Staff described to us people's care needs and what people really liked to support their independence. Prior to visiting people in their homes, management staff described to us the anxieties people had and how they responded to visitors. The knowledge staff had was also demonstrated by the positive impact this had had on people's lives. For example, for people who had previously not had the freedom to make choices about their nutrition. Staff had supported the person in a person centred way and enabled them to be more confident about themselves and their independence. This showed us their in-depth understanding of the people they cared for. One care staff said, "What I like most about my job is seeing someone smile after helping them." Another person told us that they had been informed by staff, that, if for any reason they could not visit their relative, then the staff would bring their relative to see them.

A care manager told us and we saw that people were supported to access Independent Mental Capacity Advocates or relatives who had legal responsibilities to advocate for their family member. Advocates are people

Good

# Is the service caring?

who are independent of the service and who support people to make decisions and communicate their wishes. Information about how to contact advocacy services was available in all of the people's own homes.

Good

# Is the service responsive?

## Our findings

One person told us that they had been supported by the service for several years. They said, "The staff have got to know me so well and my preferences." A relative said, "I feel very involved and know how to contact the manager and the organisation at any time if I have any queries or need to talk about anything." Another relative said, "I would like [family member] to do more activities but it is not always possible due to local transport and staff that can't drive." We saw that additional transport had just been delivered at the service's head office. This was in response to an increase in people being supported out in the community as well as staff travelling to see people.

The service supported people who lived in different areas to meet other people who used the agency in the community. There were trips organised and people also met at a local music centre. There, an array of musical activities were arranged, including bands, discos and games. Staff arranged activities including football matches and parties and people were supported to attend these events if they wanted to go. Some people were encouraged and supported to attend work placements out in the community. This helped build their social and life skills. The manager explained to us that throughout the homes where people had non-verbal communication skills, people were shown pictures or objects relating to an event; staff interpreted their 'yes' or 'no' responses as to whether they wished to attend or not. This meant that people were supported as far as practicable to maintain and improve their levels of independence.

The management staff and representatives of the provider had taken time to support care staff to work with people and their relatives. This also included other significant people in order to obtain and record relevant information about people's life histories. Staff said this had helped them gain an individual understanding of what was really important to each person. The knowledge gained by care staff was used to assist people to be as involved in the assessment and planning of their care. This also helped staff identify people's interests and hobbies and how these could be maintained. For example, going bowling, martial arts classes, swimming and shopping. One person who liked brass bands was being supported to attend a brass band concert. We also saw and staff told us that they supported people to maintain links with the local community such as going out for a meal or to see, or be seen by relatives at the weekend. Another person said, "The staff helped me paint my home and they did this in their own time."

We saw that people's care plans included a record of people's achievements. For example, as a result of certain food intolerances or allergic reactions. This information provided guidance to staff on the care the person needed. For example, one person was enabled to choose where they wanted to eat and drink out and gain new skills in menu planning and shopping for their food

One relative told us, "They [care staff] take my [family member] to Tai Chi classes. It's amazing what a difference this has made [to their family member's quality of life]." One person said, "If I ever need to alter may care I just need to call the office or speak with them [care staff]." One person had lived in their home for many years and they now required the use of a wheelchair when out of their home. The service manager had negotiated, with the housing association, for them to be able stay in their home with adaptations. An occupational therapist, specialising in learning disability, advised with the planning for the renovation of this person's home. This showed us that the provider and its staff considered the aspects of people's care that were meaningful and important to them.

Care plans contained a level of information based upon each person's needs and these plans prompted staff, especially new staff, to assist people to maintain their independence. Staff told us that they found care plans easy to follow and that these could be referred to at any time.

The service had up-to-date complaints policies and procedures in the form of a service user guide. This included details on how to contact other organisations such as the CQC or the Local Government Ombudsman. People told us that staff gave them opportunities to raise concerns about their care and that action was taken where required. People confirmed that they were supported to access these if required. However, this was not provided in an easy read format. This limited the access some people may have needed to support them raising any concerns. Staff told us that they would know if a person was unhappy and would take action in response to such changes. This included changes in the amount of support provided or where prescribed medicines were needed to be changed.

Good

# Is the service responsive?

One person knew how to make a complaint and said, "[I ]tell them [care staff] what I want, make it plain. I am not afraid to do so." The record of complaints we viewed demonstrated that people's concerns and complaints were investigated and responded to. Reviews of complaints were undertaken to help identify any potential trends. We saw that people's concerns were specific and not of a general nature.

One person said, "They [management staff] are always coming to see me and this is where things get updated." We saw that people's' care plans had been reviewed regularly and with the person's input. Changes that were made included the amount of support people needed and where the person had become more independent.

One person said, "Everything is perfect. The office staff are amazing." Another person said, "I have never had to contact the office." A member of staff said, "Even if it is something I can resolve straight away I always inform the office to make sure that these changes are included in the person's care plan." This showed us that staff knew how to respond to people's concerns.

Requires improvement

# Is the service well-led?

## Our findings

During our review of records of managers' visits to people's homes we found that medicines administration recording errors had occurred. The local authority contracts team informed us that they had visited people using the service. They had also found medication recording omissions. The service and its staff had not reported these as potential safeguarding issues. Audits undertaken by the provider had been completed at some people's homes. However, not all incidents had been reported correctly. This included those for potential harm or incidents where the police had been involved.

The provider is required, by law, to notify the CQC of certain events such as those where the police were involved or there was suspected abuse. Prior to our inspection we found that there had been three occasions that we were aware of, where the provider had failed to notify us without delay. We were only informed of some events once we informed the provider of their responsibilities. In addition, we found two further incidents where the local authority had been informed about safeguarding concerns, but again the provider had not informed us.

This was a breach of The Care Quality Commission (Registration) Regulations 2009 regulation 18.

Strong links were maintained with the local community and this included assisting people to attend a day centre, going to work, swimming, martial arts classes and bowling. The operations manager and staff confirmed that as well as using a company car people were supported to access public transport. Some people were also supported by their family members and relatives. This showed us that there were measures in place to reduce the risk of people's social isolation.

The service did not have a registered manager. The previous registered manager had left in October 2015. The provider had appointed a new manager but they had not yet taken up their position.

The operations manager told us and we saw that staff were rewarded and recognised for their achievements. For example, having awards for their standards of work and the differences they had made to people's lives. Care staff told us about the values of the service. These included treating people as an individual. Examples given included supporting people and their relatives with a special birthday party. One relative said, "The staff do things in their own time and without them I couldn't organise [special occasions]."

The operations manager told us how people and staff were actively involved in developing the service. This included regular face to face discussions with people, staff and management meetings. Other ways quality assurance monitoring was undertaken was by management staff completing spot checks of staff's medicines administration practice, standards of care provision and infection control. This helped the provider determine whether any person needed additional support. One person told us, "I see the LDP [Learning Disability Partnership] who support me with my care and check everything is okay."

Each person appeared at ease and knew who the service's managers were. One person said, "I see [name of their manager] when they come to see me and ask how everything is." One manager visited a residence on a weekly basis and had daily contact with the supervisors of that residence. A daily rota was sent to staff and people or their relatives from the provider's office in Ely. No agency or bank staff were now planned to be used. This showed us that the provider considered the continuity of people's care.

People, and their relatives, told us what the provider did well with regard to their care needs. One person said, "There is always going to be the odd little thing to improve. I have never had any issues and I can't think of anything they could do better for me." A relative told us, "Staff going the extra mile by helping in their own time and being there for my [family member]. I don't know how they have such patience." This helped confirm that the provider and its staff considered and acted upon what people told them.

The service had an audit process in place to monitor the effectiveness of any actions taken for identified concerns. This included analysing information from management visits to people and staff caring for them. We found that some issues such as staff signing for medicines before they had actually been administered had been identified and acted upon. Measures such as the time or way medicines had to be administered were then implemented. The provider had just received the results of the previous 'registered manager' audits and quality assurance survey

Requires improvement

# Is the service well-led?

2014-2015. The provider had not yet had the opportunity to put an action plan in place for those areas which required improvement. The operations manager told us that this was a priority area for them.

Staff were supported with supervisions, appraisals and on the job mentoring. Regular staff meetings gave staff the opportunity to comment on any areas they felt would benefit people. One member of care staff said, "The meetings are a great opportunity to make suggestions and learn from other staff on what works for each person." If there was a situation needing urgent attention staff told us that they didn't have to wait. For example, if as a result of a review of daily care notes that they felt that people had become more, or less, independent.

Staff commented favourably about the support that management provided. One member of staff said, "They [managers] are only a phone call away. I go to the office most weeks and I can ask for any support there, if I need to." Another said, "If I ever need support my manager's door is always open." A third member of care staff said, "As well as being introduced to people during my induction [training] managers are always there if I need any guidance or information on the support the person needed." A relative told us that for the majority of occasions, any new staff were always introduced to their family member.

We were told and new staff confirmed that they were completing the requirements for training under the Care Certificate [A nationally recognised standard for care staff training]. This helped support staff development and in delivering a consistent standard of care provision.

Staff told us that they were aware of whistle-blowing procedures and would have no hesitation in reporting their concerns. This was if ever they identified or suspected poor care standards. They said that they would "definitely be supported" if ever a concern was identified.

The operations manager told us and we saw that they kept their staff up to date with information from national organisations; this included such as those for people with a learning disability and for service providers offering a supported living service. This helped ensure that staff were working to the latest standards of care provision.

Staff had been established in roles such as a being a champion for people with behaviours which challenge others and autism. This was planned to help mentor those staff in developing a similar level of knowledge and skills in caring for people living with these conditions.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>How the regulation was not being met:<br><br>The registered persons had not always notified the Care Quality Commission about incidents they are required, by law, to do so.<br><br>Regulation 18 (1) (2) (e) (f). |