Somerset County Council (LD Services)

Somerset LD Services 3

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 August 2016 and was carried out by one inspector. The provider was given 48 hours' notice of inspection to ensure the registered managers were available to meet us and also to make arrangements for us to visit people in their own homes.

The service is registered with the Care Quality Commission (CQC) for the provision of personal care in people's own homes. This includes assistance or prompting with washing, toileting, dressing, eating and drinking. At the time of the inspection the service supported 94 people with a learning disability or autistic spectrum condition. This included 43 people supported by the Yeovil and Chard area network domiciliary care teams and 51 people in supported living shared occupancy houses. The shared occupancy houses supported by the service were: Churchmoor Farm; Rosedale; Orchardleigh; Bradley View; The Seasons; Vestry Road; Hillcrest Road; and Grove Avenue.

The service also provided other forms of social care support which are not included within CQC's registration requirements for a supported living service. For example, in addition to personal care, the service assisted people with their housekeeping, shopping, attending appointments and other independent living skills.

The service provided people's personal care and support under a separate contractual arrangement to people's housing provision. People's accommodation was provided by separate housing providers or landlords, usually on a rental or lease arrangement. This meant people could choose an alternative support service provider if they wished. Nevertheless, the service was happy to support people with reporting any faults or maintenance requirements to their respective landlords or housing association.

People who used the service had varying degrees of difficulties and support needs, ranging from mild to severe learning disabilities and autistic spectrum conditions. Some people had complex needs and required 24 hour support, whereas others were relatively independent and just needed assistance for a few hours each week.

There were two registered managers for this 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 registered managers described the service philosophy as "The customer comes first. It is their home and not a work place" and "It is about providing support to individuals to meet their needs and aspirations. Person centred care, individualised as much as possible".

People who used the service told us they felt safe and secure with the staff supporting them. A person who received support from the domiciliary care team said "They always give me the rotas and let me know who is coming. They all wear ID badges". Another person said "They help me with my shower. I feel safe, no worries.

They also do shopping with me. I know what they buy with my money and no one ever borrows or takes my money". This showed people knew which staff were coming and when, which meant they were less vulnerable to unexpected callers or strangers. It also showed people were protected from financial abuse.

There were sufficient numbers of staff deployed to meet people's individual needs and to keep them safe. Before people started to use the service, a detailed assessment of their needs was carried out. This included the staffing support required. Where people's needs increased the staffing hours were increased. As people became more independent staffing support was reduced. All of the staff we spoke with told us the staffing levels were appropriate to meet the needs and choices of the people they supported. Staff also supported people to access external health and social care professionals when needed. Feedback from an external professional stated "I found that the team is very caring, reflective and receptive to new recommendations, which makes our collaborative work effective".

Each individual service had its own team of regular staff. This ensured people were familiar with the staff who supported them and the staff understood their needs and preferences. Staff were available to support people with personal care when needed, but the service tried to encourage people to be as independent as possible. This boosted people's confidence and self-esteem and enabled them to become more self-reliant.

Staff received individualised communication training to enable them to understand and communicate with people who had limited or no verbal communication skills. Where people lacked the mental capacity to make certain decisions the service ensured their human rights were protected.

All of the interactions we observed between people who used the service and the staff were friendly and caring. One of the people in a shared occupancy house said "We are all friends in the house". A person who received support from the domiciliary care team said "They treat me lovely, nice and kind". Feedback from people's relatives included "I find the staff to be polite, patient and above all treat people with dignity and respect"; "Fantastic, attentive and caring staff"; and "Staff constantly go the extra mile".

Systems were in place to ensure people received their prescribed medicines safely. Most of the people who received domiciliary care were able to self-medicate although occasionally they required assistance or prompting to take their prescribed medicines. Many of the people who lived in the shared occupancy houses had their medicines administered by staff, following a medicines risk assessment.

We found high levels of staff satisfaction across the whole service. Staff said the team leaders, team managers and the registered managers were all very accessible and supportive. The registered managers were visible and visited each service on a regular basis. The service was facing a major transition from local authority control to a new social enterprise company. Staff told us they had been briefed about the future changes and, although this was obviously unsettling, the majority were hopeful and optimistic about the future direction.

The provider had an effective quality monitoring system to ensure standards of service were maintained and improved.

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.

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual support needs.

People were protected from the risk of abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to maintain as much independence as possible and to remain safe.

Is the service effective?

Good

The service was effective.

People received personal care and support from staff who were trained to meet their individual needs.

People were encouraged to carry out day to day tasks with staff support to develop daily living skills and to maintain their independence.

People were supported to maintain good health and to access health and social care professionals when needed.

The service acted in line with current legislation and guidance where people lacked the mental capacity to make certain decisions about their support needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect and were supported to be as independent as they wanted to be.

The staff and management were caring, friendly and considerate.

Staff had a good understanding of each person's preferred

communication methods and how they expressed their individual needs and preferences.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Good

The service was responsive.

People were consulted and involved in decisions about their support needs to the extent they were able to express their preferences.

People's individual needs and preferences were understood and acted on.

People's views and suggestions were taken into account to improve the service.

Is the service well-led?

Good

The service was well led.

The service had a caring and supportive culture focused on meeting people's individual support needs and increasing their social inclusion.

People were supported by a motivated and dedicated staff team and accessible and approachable management.

The provider's quality assurance systems were effective in maintaining and promoting the standards of service provision.

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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 3 August 2016 and was carried out by one inspector. The provider was given 48 hours' notice of inspection to ensure the registered managers were available to meet us and also to make arrangements for us to visit people in their own homes. The service is registered with the Care Quality Commission (CQC) for the provision of personal care in people's own homes.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's 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 the improvements they plan to make.

The service was last inspected on 30 June 2014. At that inspection all quality and safety outcomes were compliant with the regulations. No concerns were identified at the previous two inspections either.

During this inspection we met with the service's two registered managers, visited five of their shared occupancy houses, and spoke to 10 people who used the service and 17 staff. The staff included: team managers, assistant managers, support leaders, support workers and support assistants. Following the inspection, we telephoned eight more people who were supported by the domiciliary care teams and five domiciliary care staff.

We reviewed 2015/16 and 2016/17 'stakeholder feedback' about the service from people's relatives and professionals involved with people's care. We also reviewed three people's care plans and other records relevant to the running of the service, including: staff training records, medication records, complaints and incident files.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and secure with the staff supporting them. For example, a person who lived in one of the shared occupancy houses said "The staff are all nice. I'm happy with all of them, no problems". A person who lived in another house said "Nobody's nasty to me. If they were I would walk away and tell other staff". All of the people we met looked relaxed and happy with the staff who supported them. All of the interactions we observed between people and staff were friendly and appropriate.

Similarly, a person who received support from the domiciliary care team said "They always give me the rotas and let me know who is coming. They are pretty good and let me know if someone's off sick. They all wear ID badges". Another person said "They help me with my shower. I feel safe, no worries. They also do shopping with me. I know what they buy with my money and no one ever borrows or takes my money". These comments showed people knew which staff were coming and when. This made them less vulnerable to unexpected callers or strangers. It also showed people were protected from financial abuse.

People who used the service were potentially vulnerable to abuse due to their learning disabilities. The service protected people from the risk of abuse through appropriate policies, procedures and staff training. Staff told us they had no concerns about any of their colleagues' practices but they would not hesitate to report something if they had any worries. Staff were confident management would deal with any concerns and ensure people were protected.

The risk of abuse to people was reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Care plans contained risk assessments with measures to ensure people received safe personal care and support. For example, there were risk assessments and control measures for managing anxiety and aggression, epileptic seizures, people's finances, medicines management and choking. Staff told us they received positive intervention training to de-escalate situations and keep people and themselves safe.

All incidents were investigated and action plans put in place to minimise the risk of recurrence. The service reported all significant incidents to the local authority's community team for adults with a learning disability. Where appropriate, these incidents were referred on to the safeguarding team for further investigation. Our records showed the registered managers also informed the Care Quality Commission of notifiable incidents.

The service had systems for dealing with emergencies and other unplanned events. Each service had their own team crisis plans; there was an on-call senior manager rota and an emergency night support protocol to respond to unforeseen emergency situations. Although the service was not directly responsible for people's premises and equipment, staff still carried out risk assessments and checks to ensure the physical

environment was safe. If any concerns were identified, the service informed the relevant landlord or housing association for action. The service also had a comprehensive range of health and safety policies and procedures to help keep people and staff safe.

There were sufficient numbers of staff deployed to meet people's individual needs and to keep them safe. Before people started to use the service, a detailed assessment of their needs was carried out. This included the staffing support required. This ranged from 24 hour one to one staff support for people with higher dependency needs, to just a few hours support each week for people who were relatively independent. Where people's needs increased the staffing hours were increased. As people became more independent staffing support was reduced. All of the staff we spoke with told us the staffing levels were appropriate to meet the needs and choices of the people they supported.

Each individual service had its own team of regular staff. This ensured people were familiar with the staff who supported them and the staff understood their needs and preferences well. Staff worked flexibly to cover any absences or shortages within their 'cluster' area. A cluster was a group of services within a particular geographic area. There was a managers' on-call system for staff to access if they needed further advice or support.

Most of the people who received domiciliary care were able to self-medicate although occasionally they required assistance or prompting to take their prescribed medicines. Many of the people who lived in the shared occupancy houses had their medicines administered by staff, following a medicines risk assessment. Systems were in place to ensure all people received their medicines safely. Staff received medicine administration training and shadowed more experienced staff until they were assessed as competent by their manager. This included observation of staff medicine administration practices and completion of a detailed medicines administration questionnaire. Staff were reassessed every year to ensure their practice continued to be safe.

We observed medicines were kept in suitable storage facilities and medicine administration records were accurate and up to date. Staff said they checked to ensure people took the correct medicines at the right times. The service managers also carried out monthly audits to check the accuracy of medicine records and supplies.

There had been a low incidence of medicine 'errors' over the last 12 months, relative to the total number of medicines administered by this service. No harm had been caused to people and most of the errors were due to relatively short delays in administering a person's medicine at the specified time. If people who self-medicated refused to take their medicine this was recorded as a medicines 'error'. All medicine errors were reported to the community team for adults with a learning disability to decide whether a safeguarding investigation was appropriate.

Good

Is the service effective?

Our findings

People told us the service was effective in meeting their personal care and support needs. A person who lived in one of the shared occupancy houses said "I'm happy here all the time and all the staff are nice". A person who received support from the domiciliary care team said "I explain what I need and they help me with it. Everything's all fine, really". Feedback from an external professional stated "I found that the team is very caring, reflective and receptive to new recommendations, which makes our collaborative work effective".

Staff understood people's needs and preferences and engaged with each person in a way that was most appropriate to them. Staff training included; safeguarding vulnerable adults, the Mental Capacity Act (2005), epilepsy, medicines management, positive interventions, first aid, food hygiene, moving and handling and other topics specific to people's individual needs. For example, where necessary staff received individualised communication training to enable them to understand and communicate with people who had limited or no verbal communication skills. The service used an inclusive communication environment (ICE) process to enable staff to identify the right tools and methods to effectively communicate with people. This included sign language, picture boards, symbols, and other physical forms of communication. During our visits we observed staff employing a range of different communication methods appropriate to the people they were supporting.

Staff told us other professionals involved with people's care sometimes attended team meetings to provide training specific to an individual's needs. This included psychologists, speech and language therapists and GPs.

New members of staff told us they had completed a comprehensive induction programme. This involved an intensive seven day block induction course as well as a local service induction. This included shadowing more experienced staff until they became familiar with the needs of the people they were supporting. During their induction, staff completed a range of mandatory and service specific training. They had 12 weeks to complete a work book toward gaining The Care Certificate. The Care Certificate covers an identified set of standards which health and social care workers are expected to adhere to. As part of their assessment, service managers observed new staff practices and sought the views of people who used the service and other staff. This enabled them to assess the member of staff's competency and their suitability to work with people who used the service.

Training records showed staff were up to date with their mandatory training. The provider also supported staff with continuing training and development, including vocational qualifications in health and social care. This training helped to ensure the people who used the service received effective support based on current best practices.

Staff had one to one supervision sessions with their line manager every four to six weeks. They told us they could also request a discussion with their line manager, or a more senior manager, whenever they needed. Shift hand-overs and monthly staff team meetings were also used to discuss any care or support issues and

to share good practice. Staff attended annual performance and development appraisal meetings. These meetings provided regular opportunities to review staff performance, discuss best care practice, and identify any additional staff training or development needs.

Staff in each of the services visited, said everyone worked really well together as a supportive and flexible team and this helped ensure people received the support they needed. One support worker said "Everyone is really lovely and supportive. It's a really nice supportive team". Another support worker told us "I was made extremely welcome to the team. They are so helpful and accommodating". A support team leader said "I'm very lucky, I've got a flexible and supportive team and my line manager is fantastic".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The Deprivation of Liberty Safeguards (DoLS) authorisation procedure does not apply to supported living services. For this type of service, where a person's freedom of movement is restricted in a way that may amount to deprivation of their liberty it has to be authorised by the Court of Protection.

We found the service was working within the principles of the MCA. Staff had received training and had an understanding of the requirements of the MCA. When people lacked the mental capacity to make certain decisions the service followed a best interest decision making process. The service also reviewed any restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom and choices. A number of people who used the service had current Court of Protection orders, allowing the service to restrict certain aspects of their liberty, rights and choices in order to keep them safe.

When required, staff assisted or prompted people to have sufficient to eat and drink and to have a balanced diet. This ranged from supporting people to do their own food shopping to helping people prepare their meals. Where applicable, staff supported people with special dietary needs. For example, some people were prescribed a soft diet to avoid the risk of choking, following assessment by a speech and language therapist. Another person with diabetes did not tolerate injections and had to follow a strict diet. The hospital diabetic nurse visited the service to provide staff training in observing and monitoring the person's health condition.

Staff helped people to maintain good health by prompting and supporting them to attend hospital and other health care appointments. Records showed people were supported to see a range of health and social care professionals including: GPs, psychologists, social workers, epilepsy and diabetic nurses, speech and language therapists, dentists, opticians and chiropodists.

Personal care and support was provided separately to the provision of people's accommodation. However, the service was happy to support people with reporting any faults or maintenance requirements to their respective landlords or housing association. Some people leased or rented their own individual flats from housing associations or private landlords. Other people lived in shared occupancy houses and had tenancy agreements for their individual rooms. People were able to choose how they wished to have their rooms decorated and furnished within the terms of their tenancies.

Good

Is the service caring?

Our findings

All of the interactions we observed between people who used the service and the staff were friendly and caring. Without exception, people told us they liked the staff and would talk to staff if they needed anything. One of the people in a shared occupancy house said "We are all friends in the house and staff take me to visit my Mum once a week". A person who received support from the domiciliary care team said "They treat me lovely, nice and kind" and another person said "They are all very respectful. They are nearly always on time but will ring me if running late, but they're not very often late". Feedback from people's relatives included "I find the staff to be polite, patient and above all treat people with dignity and respect", "Fantastic, attentive and caring staff", and "Staff constantly go the extra mile".

During our visits we observed people were comfortable and relaxed with the staff supporting them and the staff were considerate of people's feelings. For example, in one of the shared occupancy houses we were interviewing a team leader in the staff overnight room. A person who used the service wondered in and sat down beside them. The team leader welcomed the person in and told us it was alright for the person to be present as they did not have the mental capacity to understand the things we were talking about. They said the person just liked to be in the company of others.

When staff spoke with us they were caring and appreciative of the people they supported. A support worker said "It is a very fulfilling job. Every day I get a hug or a smile from someone". An assistant team manager told us "I couldn't be happier. The customers (meaning the people who use the services) are the bonus and are lovely people to work with. They are exceptionally nice and make my day".

Staff were available to support people with personal care when needed, but the service tried to encourage people to be as independent as possible. For example, people were encouraged to carry out as much of their own personal care and cooking as possible, with just a little assistance or prompting from staff when needed. A member of staff said "It's important we know people's personal care needs and what they can do for themselves. We make sure they do as much as they can for themselves". Encouraging people to become more self-reliant with their daily living activities helped to boost their confidence and self-esteem.

Each service had its own regular team of permanent support staff. This helped ensure staff were familiar with and understood people's individual support needs and preferences. It also meant staff understood people's individual communication methods and were better able to assist them to express themselves and to contribute to the assessment and planning of their care.

Staff respected people's privacy and dignity. For example, staff told us they always ensured doors were closed and curtains or blinds drawn when personal care was taking place. People also told us staff assisted them in a discrete and respectful manner. For example, when out in the community, if people required personal care the staff looked for suitable public conveniences where they could provide the necessary support.

People were supported to maintain ongoing relationships with their families. Some people received staff

support to visit their families and the service encouraged relatives and friends to visit people in their own homes where appropriate.

Staff were aware of people's beliefs and preferences and respected their views and choices. Care plans included any known information about people's end of life preferences and any cultural or religious beliefs. For example, a person in one of the shared occupancy houses had a complex health condition and was receiving end of life care, supported by a multi-disciplinary team. There was a written funeral plan included in their care and support file. The service also had managers who were trained in the Gold Standards Framework for end of life care. They were available to offer further advice and support to any of the teams who were supporting people nearing the end of their life.

Good

Is the service responsive?

Our findings

The service provided personal care based on people's assessed needs and preferences. This included assistance or prompting with washing, toileting, dressing, eating and drinking. Some people needed 24 hour support with all of their personal care needs. Others were relatively independent and only needed limited support or prompting.

People told us they were aware their support needs were recorded in a care plan, although most people said they would simply discuss any issues with their support staff. One person said "Yes, I've got a care plan and the staff read it to me. They told me all about it and I try to understand it". Another person said "I just have a word with them and it gets sorted". All of the people we spoke with told us they knew who to go to, if they had any issues about their care, or the support they received. They said they would speak to their support worker, the team leader or the manager, and they were confident they would take appropriate action.

The service also provided other forms of social care support which are not included within CQC's registration requirements for a supported living service. For example, in addition to personal care, the service assisted people with their housekeeping, shopping, attending appointments and other independent living skills.

The amount of support people required was initially assessed by the local authority's community social work team. The relevant service team leader then put together a comprehensive 'support for living' plan in consultation with the person who used the service and their relatives or other representatives. The support for living plans provided clear guidance for staff on how to support people's individual needs, aspirations and choices. They included an assessment of people's needs, their support plan, risk assessments, health appointment records, medicines, health action plan, personal money records, significant events and, where appropriate, details of their tenancy agreements. Copies of the care and support plans were kept in the relevant service's office as well as in people's own homes, if they were happy to keep them there. People in shared occupancy houses could decide to keep their care plans in their own rooms or alternatively in a secure storage area of the home. Staff also recorded important notes, events or appointments in staff hand over books and in people's individual diaries kept within each person's home.

One of the registered managers told us the service was not prescriptive about writing detailed daily notes about people's routine personal care. They said people should not be subjected to having their "life under a microscope". However, any significant or out of the ordinary matters had to be recorded or 'sign posted' in other ways, such as in the staff hand over books, people's diaries or calendars, or on wall charts in people's own rooms. For example, a person in one of the shared occupancy houses showed us their personal daily diary. This included details of appointments, activities and also some prompts to remind them about aspects of their personal care. The diary also contained pictures to help them with their understanding.

Care and support plans were reviewed by the support team leaders and team managers on an ongoing basis to ensure they remained appropriate and up-to-date. They reviewed people's care and support plans on a monthly basis or when there was a significant change to the person's support needs.

People had a say in which members of staff supported them. For example, one of the people told us they did not get on well with a particular member of staff and when they mentioned this to the person's supervisor the member of staff was replaced with someone else. Staff members of the same gender were also available to assist people with personal care, if this was their preference. A team manager told us they tried hard to ensure people and staff were compatible. If a person was not happy being supported by a particular member of staff, they would move the staff member to another role.

The service sought people's views through a variety of methods. This included routine discussions with people and their relatives, the use of service feedback forms, 'tenants meetings' in some of the shared occupancy houses, and spot checks and visits by domiciliary care managers and team leaders. During these visits the managers and team leaders supported people to complete an internal quality assurance form, covering issues such as: the politeness of staff and how happy people were with the staff supporting them.

People told us the staff and managers were very accessible and approachable and they could talk to staff, or any of the managers, if they had any issues or concerns.

The provider had an appropriate policy and procedure for managing complaints. The policy included agreed timescales for responding to people's concerns. In the last 12 months the service had received one formal complaint. The registered manager had taken appropriate action to resolve the issues raised to the satisfaction of all parties.

Good

Is the service well-led?

Our findings

The service covered a large geographic area with two domiciliary care networks and eight supported living shared occupancy houses. There were two registered managers for this service. One described the service philosophy as "The customer comes first. It is their home and not a work place". The other registered manager added "It is about providing support to individuals to meet their needs and aspirations. Person centred care, individualised as much as possible".

The service promoted this approach through staff training, staff meetings, shift hand overs and one to one staff supervision and appraisal sessions. The provider's policies, procedures and operational practices were also geared to supporting a person centred approach to care planning and delivery.

All of the staff and managers we spoke with appeared motivated and committed to ensuring people received the support they needed and wanted. It was clear they were focused on the well-being of the people they supported. The service was facing a major transition from local authority control to a new social enterprise company. Staff told us they had been briefed about the future changes and, although this was obviously unsettling, the majority were hopeful and optimistic about the future direction.

Every service we visited considered they had the best staff team and the best manager. This was indicative of the high levels of staff satisfaction we observed across the service. Staff told us they respected and admired their team supervisors and managers. Staff said team leaders, team managers and the registered managers were all very approachable and accessible and they could turn to them for advice or support whenever needed. They said the registered managers visited their services on a regular basis and staff felt they could go direct to the registered managers, if this was appropriate. A team leader said "[Registered manager's name] is very accessible, there are no barriers. They visit the service and are visible". A team manager told us "[Registered manager's name] is very good and approachable. They give very good support and are always available at the end of the phone or by email".

Decisions about people's support needs were made by the appropriate staff at the appropriate level. Specialist support and advice was also sought from external health and social care professionals when needed. There was a clear staffing structure in place with clear lines of reporting and accountability. The support workers reported to the team leaders, who reported to the team managers, who reported to the service managers.

The provider had a quality assurance system to check they met people's needs effectively. The team managers and assistant team managers carried out a programme of monthly audits and safety checks within their respective services. These included reviewing care plans, medicine administration records, significant events and emergency plans. They then completed a monthly service report to the appropriate registered manager as part of the provider's quality monitoring process. Where action was needed, it was noted on a service action plan and progress was checked at the next service review. For example, if errors or omissions were identified in care records these were checked for accuracy at the next review. Where appropriate, staff were given additional training or supervision to ensure they met the required standards.

The quality monitoring systems helped ensure people benefitted from a service committed to high standards of support and to continual improvements.

To provide further quality assurance, one of the provider's senior managers had been appointed to carry out audits of each individual service, based on the Care Quality Commission's (CQC's) five questions. The audit reports showed the findings against each key line of enquiry, and identified areas of good practice and areas requiring development. A RAG (Red, Amber, Green) rating was used to classify the audit findings into: Red = requires immediate attention; Amber = requires some attention; Green = meeting acceptable standards. The relevant service manager was responsible for preparing and implementing an action plan to respond to the audit findings.

These quality checks and audits helped ensure people continued to receive good quality care in a safe and homely environment.

To the best of our knowledge, the registered managers notified CQC of all significant events and notifiable incidents in line with their legal responsibilities. The registered managers promoted an ethos of honesty, learned from mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People, relatives and other care professionals were encouraged to give their views on the service through routine conversations, care plan review meetings, spot checks and customer feedback forms. The most recent quarterly analysis of feedback received by the service showed a high level of satisfaction with the staff and with each of the individual services.

The registered managers told us there were a number of forums for exchanging information and ideas and fostering best practice. These included regular team meetings and training, a corporate team briefing system, internal publications, cluster working (services working together in a particular geographical area) and peer support meetings, for example team manager meetings. Managers and staff also attended conferences and seminars and accessed a range of online resources and training materials from other service related organisations.

The service participated in the Care Certificate Consortium, an accredited scheme to support staff through gaining a recognised qualification in care. It had British Institute for Learning Disabilities accreditation for physical intervention training and techniques. Some managers were trained in the Gold Standards Framework for end of life care. The service also received relevant information about current legislation, regulations and standards from the Council's policy and practice manager.

The service worked in close partnership with other local health and social care professionals. More specialist support and advice was also sought from relevant professionals when needed. This helped to ensure people's health and wellbeing needs were met.

Most of the service's links with the local community revolved around people's activities and their families. Where staff support was needed, people were supported to go out on a regular basis and to engage in the community to the extent they were able to. This included social and leisure activities, visits to local resource centres, family visits, shopping and other trips out. The Provider Information Return (PIR) stated the service was currently developing a volunteering service. This was intended to increase the opportunities for people to access more community activities. The plan was to recruit suitable local volunteers and to match them to people who used the service.