Yorkshire Housing Limited

Lifeworks

Inspection report

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12 April 2017

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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

Summary of findings

Overall summary

Our inspection of Lifeworks took place between 3 and 12 April 2017 and was announced to ensure the registered manager was available. This was our first inspection of the service.

Lifeworks is part of the Yorkshire Housing group and provides a domiciliary care and supported living service to younger and older adults who have a learning disability or autism spectrum disorder. At the time of our inspection there were 30 people receiving the regulated activity of personal care within eight supported living sites. Yorkshire Housing is currently working with the local authority to transition the Lifeworks services to other providers.

The service had a registered manager in post. 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.

People told us they felt safe. Safeguarding policies and procedures were in place and staff had received safeguarding training, although some training required renewing. Staff we spoke with were able to identify types of abuse and what to do if they had safeguarding concerns.

Risks to people were assessed and appropriate measures put in place to positively manage and review these. Incidents and accidents were reported with outcomes and actions taken as a result.

Medicines were safely managed with some people assessed as able to manage their own medicines to promote independence.

We saw staff were recruited safely to ensure their suitability to work with vulnerable adults. Sufficient staff were deployed to meet the care and support needs of people living at the service. Staff were suitably trained and supported with regular supervision and annual appraisals.

People's health care needs were usually met. One of the services where some missed appointments had occurred had commenced a new shift system to mitigate the risk of this happening in the future.

People were supported to consume a healthy diet and encouraged to be as independent as possible with meal preparation.

People told us they liked living at the service and staff were kind and caring. Staff we spoke with knew people well including what they liked to do and their care and support needs. We saw staff interacted with people with respect and supported their independence where possible.

Plans of care were clear and person centred with clear emphasis on independence and achievement of

goals. Regular reviews and meetings were held where any changes were discussed with people and/or their relatives. Best interest meetings and evidence of consent were documented.

Activities were planned on an individual basis and according to people's choice.

Systems were in place to log, investigate and respond to complaints. Complaints were responded to appropriately and people we spoke with understood how to make a complaint. However, no central log was kept of complaints within the service to analyse for trends and help drive service improvements.

We received inconsistent feedback about the management and quality of the service. Although people living at the service told us they were happy, some relatives were concerned about communication, management and the use of agency staff. Some staff also expressed concerns about communication, poor morale and staff divisions at one of the service houses.

A range of audits and checks were in place to monitor and improve the service.

The management team were enthusiastic about the work they had carried out so far and plans for future improvements. Regular meetings were held with people living at the service, relatives and staff to discuss concerns, activities and improvements within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe living at the services. Safeguarding processes were in place and staff understood how to recognise and report abuse.

Medicines were managed safely.

Staff were recruited safely to ensure they were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff had received regular training and support.

The service was compliant with the legal requirements of the Mental Capacity Act (MCA) 2005.

People's consent was sought with a high regard for people's choice.

Is the service caring?

Good

The service was caring.

Staff demonstrated a caring attitude to people living at the service and knew them well.

People and their relatives were involved in developing plans of care.

People's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

Care records were person centred and contained clear

information about people and their care and support needs. Support plans focussed on goals and aspirations with a clear strategy of increasing people's independence.

People's support plans and goals were regularly reviewed together with the person and/or their relatives.

A range of social activities were encouraged according to people's choice and preferences.

Is the service well-led?

Requires Improvement

The service was well led although some improvements needed to be made.

Feedback about the management of the service was inconsistent and morale was low amongst some staff.

A range of quality audits was in place although systems for collation and analysis of complaints needed to be commenced.

Regular meetings were held with people who lived at the services, relatives and staff.

Lifeworks

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, 4, 8, 10, 11 and 12 April 2017 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager was available.

The inspection team consisted of two adult social care inspectors 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. The expert-by-experience used on this occasion had experience of learning disabilities.

Before the inspection we gathered and reviewed information about the service, including notifications received from the service and information from the local authority safeguarding and contracts teams. We also had asked the provider to complete a Provider Information Return (PIR). This is a form which gives information about the service, what it does well and improvements planned. The service returned this in a timely manner and we took this into account when making our judgements.

During the inspection we used various methods to help us understand the experiences of people who used the service. Before our visit to the service offices we spoke with six people who used the service and eight relatives on 3, 4 and 8 April 2017.

We visited the service offices on 10 April 2017 and looked at elements of four people's care records, medicines administration records (MARs) and other records which related to the management of the service including quality assurance processes and policies and procedures. We also spoke with the registered manager, an operations manager and the quality officer.

On 10 April 2017 we also visited three supported living services where we spoke with three people and three

relatives of people living at the services, three staff members, a service manager, a team leader and a deputy manager. On 11 April 2017 we spoke on the telephone with a further five staff members and on 12 April 2017 we reviewed further information the service had sent to us including three staff records and other records relating to the management of the service including training records, and records of staff and relative meetings.

Good

Is the service safe?

Our findings

People and relatives of those living at the services told us they felt safe. Comments included, "I really like it here, I can talk to the staff if I feel worried; they're great.", "Yes, I feel safe. They make sure I have my door locked because [person's name] worries me. They look after me,", and, "I can talk to any member of staff if I'm worried." A family member told us, "I think [person] is safe there, even though the home is not in a good area. [Person] wouldn't go out alone but in the home [person] feels safe."

Staff we spoke with had a good understanding of how to identify and report allegations of abuse. Staff said they were confident there was no abuse going on within the service. Staff were able to report safeguarding concerns via a computerised alerting system. We saw a system was in place to log and investigate safeguarding concerns and where appropriate ensure action was taken to improve the safety of the service. We looked at a sample of investigations which were detailed and thorough with recommendations put in place to further improve the service. A whistleblowing policy was in place.

We saw most staff had received safeguarding training and training compliance records had identified where staff had yet to attend training. This was an agenda item at a recent operational manager's meeting with actions for staff to be booked on safeguarding training as soon as possible.

We saw recruitment was safely managed to ensure staff were suitable to work with vulnerable adults. Records showed all the required checks were carried out before new staff started work. This included two written references and DBS (Disclosure and Barring Service) checks. People living at the services were involved in the recruitment process. For example, we saw information relating to a recent recruitment process where potential staff members were set a task with people who used the service. This meant the interviewers could observe interactions and receive feedback from people about their thoughts on the candidates.

The service was staffed 24 hours a day by permanent and agency staff. Staffing levels appeared to be sufficient to keep people safe although a number of staff had recently left and some agency staff were being used to cover shifts. A relative commented, "I think they are short staffed. Long standing members of staff are leaving and they rely a lot on agency staff." A staff member at one of the services said, "Sometimes mistakes (such as missing appointments) can happen because there's such a turnover of staff and inconsistency." However, we saw and other staff at the service told us a new morning shift had been commenced whereby a member of staff covered phone calls and appointments in order to mitigate the risk of missed appointments. The registered manager also told us they were now using regular agency staff from a specific agency since they were unable to recruit permanent staff due to the imminent service changes. They showed us a spread sheet used to identify which services the agency staff were familiar with to ensure continuity of staff for people living at those services. A staff member we spoke with told us, "It's good to have a good bank team and good, regular agency staff. We do seem to have regular bank and agency (staff) now." This showed the service had taken appropriate steps to address any shortfall in staff numbers and ensure staff continuity.

Some relatives commented about the levels of agency staff used. One person told us, "Regular staff are great but there does seem to be a lot of agency staff now. I suppose no one wants to take a job where they don't know what's happening," and another said, "[Person] has good communication with the staff, a very good rapport with [person's] key worker but I do have concerns about the number of agency staff they use."

Medicines were safely managed. People were assessed as to their suitability to self-medicate and some people managed their own medicines to help promote independence. Staff received training in the safe administration of medicines.

Each person had a medicines profile in place which provided clear information on the support people required to help safe administration. People told us they received their medicines correctly. One person commented, "I'm diabetic and have to have tablets, they make sure I take them."

We looked at a sample of Medicine Administration Records (MAR) and saw these were well completed indicating people had received their medicines as prescribed. We checked a sample of people's medicines and found in all cases the number of tablets in stock matched with what should have been present. Medicines were stored securely within locked cabinets and temperatures monitored to ensure storage conditions were suitable. The opening date was written on bottled medicines so staff would know when it would be no longer safe to use.

Some people were prescribed 'as required' medicines such as pain relief or rescue medicines such as Buccal Midazolam. Recue medicines are quick acting medicines intended to relieve symptoms immediately. We saw the administration of these medicines was supported by protocols to help ensure staff offered them in a safe and consistent way.

Medicines errors were reported and a medicines error database was maintained to monitor for any trends. We saw actions were taken following errors to help prevent a re-occurrence.

We saw information about accidents and incidents were reported with outcomes documented showing root cause, investigation and actions taken as a result.

Appropriate risk assessments and positive management of these were documented in people's care records. These included control methods put in place to minimise risks. For example, one person was at risk of choking due to a medical condition. We saw controls in place such as the use of thickeners added to drinks, pureed diet and supervision when eating as well as a protocol in place for how staff should act in the event of a choking episode. Staff we spoke with clearly understood the balance between keeping people safe and allowing freedom of choice.

Good

Is the service effective?

Our findings

Staff told us they received regular training and support. One staff member said, "Yorkshire housing do provide a lot of training, really good actually, they look after us." Staff all told us the training provided by the service had equipped them with the tools to perform their roles effectively including positive behaviour support to help manage behaviours that challenge. A staff member commented, "I think it's (training) excellent compared to other places. It really does go into depth about things. We get specialist training such as administering buccal." People told us they thought the staff were well trained. One person living at one of the services told us, "I think they are well trained and I like them all very much," and another commented, "Yeah, they know what they're doing."

We saw the provider had a dedicated learning and development department which oversaw staff training compliance. Training was provided through a variety of mediums including face-to-face and eLearning. Each staff member was required to complete a number of training modules and their compliance percentages were indicated on the central training records. We reviewed these and saw training such as safeguarding, medication, respect and dignity, fire safety, health and safety, tissue viability, MCA/DoLS, food hygiene and safety awareness had been completed by most staff. Service specific training such as epilepsy, Buccal Midazolam and autism training also took place. Where gaps occurred, these had been identified for action. For example, we saw the need for further staff training on safeguarding had been a topic for discussion at a recent team leaders' meeting with clear actions for addressing this. The service was also rolling out a new 'Positive Behaviour Support' training programme throughout the services to increase staff knowledge and competency in this area.

When staff first started at the service, an induction process was commenced to introduce both Yorkshire Housing and Lifeworks. This included attending training at a learning and development facility, service specific training and shadowing experienced staff. Staff new to care were also enrolled on the Care Certificate. This is a government recognised training qualification designed to equip people without care experience with the skills necessary to provide effective care and support. Successful candidates were subject to a probationary period of three or six months during which time their performance was assessed and monitored. Staff we spoke with told us their induction training had been comprehensive and equipped them with the necessary skills for the role.

Staff received regular supervision and annual appraisal and development plan meetings. Staff we spoke with confirmed supervision meetings were held every four to six weeks and were an effective way to discuss performance and any concerns. In addition, the service had introduced 'job chats' as a less formal medium to discuss good practice if concerns had been noted.

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. In the case of Domiciliary Care applications must be made to the Court of Protection. We saw the service was compliant with the MCA and no applications had needed to be made to the Court of Protection. The registered manager had a good understanding of the principles of MCA and the Court of Protection and how to apply these. Where people lacked capacity, decision making was supported by best interest process involving the family and health professionals. For example, we saw good mental capacity assessments had been put in place around the need to administer medicines to people.

We saw evidence of consent and best interest meetings in people's care records and from information received from people, their relatives and staff at the service. For example, we saw one person enjoyed going out regularly to a night club. A best interest meeting had been held with the person's social worker with consultation with staff, the person and the person's relative about the need for a second staff member to attend with them which would require extra funding. We saw this was fully documented with clear evidence of the consultation process.

We saw people had choice and control over the food they ate. People were fully involved in the creation of menus which met their individual needs and preferences. People were supported to eat a healthy and varied diet. Some people were supported to shop and cook for themselves while others had more support. Comments from people included, "They help me with food shopping and cooking. I cook casseroles and sometimes I get mixed up if I didn't have help", "They take me shopping, I go with one member of staff and they help me to choose what to buy. They help me with my washing as well", "I am very independent, some of the other people need lots of help but I don't. I cook my own food so I can choose what I fancy", "They really look after me, they help me to shop and cook and they're really friendly. Yes I like living here", "The staff look after making the meals for me because I might burn myself but I choose what I want to eat. A member of staff takes me shopping on Wednesday and I choose what to buy. I like chips and beans, smiley faces and sausages; they help me pick," and, "The staff cook but I help. We decide what we are going to eat each week before we go shopping then they go with me to get the shopping." A family member commented, "A staff member takes [person] to do [person's] shopping each week and helps [person] with [person's] cooking; [person's] well looked after." This evidenced people were given choice and control over the food they ate.

Health plans were in place which assessed people's care needs and stated what they needed to do to stay healthy. We saw evidence of some missed health appointments at one of the supported living services. However, staff told us a new daily morning shift had been introduced which allocated a member of staff to make and review health care appointments and accompany people to these if required. This showed the service had identified and actioned the need to support people more effectively with their health care needs. People told us staff supported them with their health care needs. For example, one person told us, "If I'm not well they phone the doctor for me, yes it's really, really good," and another commented, "If I needed to go to the doctors they'd make the appointment and take me."

We saw behavioural management systems in place in people's care records, such as ABC charts which documented triggers for behaviour, the behaviour itself and the potential consequences. Indicators for behaviours also included examples of how to manage the situation in the least restrictive manner possible, such as suggesting the person might like some quiet time, or offering a diversionary activity.

We saw staff used a variety of methods to communicate with people who had limited or no language skills. For example, we saw some people used communication cards and others communicated through gestures and facial movements. At one of the services staff told us how they could understand one of the people living there who had limited speech. A staff member explained how they were able to decipher what the

person was saying since they had worked with them for a long time. They said, "At first it was difficult, but now I understand what [person] is saying and it's just normal to me." One person's relatives told us, "[Person] has limited ability to communicate but because [person's] been there so long the staff can read [person] and they know what [person] wants or means."

Good

Is the service caring?

Our findings

People we spoke with were happy living at the service. Comments included, "Staff are really kind and nice, there's no one I specially like, I like everybody really", "The staff are really nice; I go out every day to work but they always chat to me when I come home and ask what I've done. They're lovely", "The staff make me laugh a lot. I like living here, they're kind, really funny. I wouldn't want to be anywhere else", "I like all the staff, I should say they're very kind, all of them, permanent, part time and agency", "The staff are very kind and they chat to me all the time. I would talk to my key worker if I was worried about anything."

Relatives all told us their family member was happy at the service and the staff were kind and caring. Comments included, "[Person] has a really good relationship with the staff", "I think the staff are very good. There's one lady there who's been like a second mum to [person] and [person's] key worker is spot on. [Key worker] helped [person] make a full Sunday lunch for us one day, which was brilliant. I've never had any worries that [person] wasn't being treated well", "[Person's] been there 20 years, so it's been a big part of [person's] life. [Person] requires 24hr care and I think that no one thought [person] would live this long. I think the fact that [person] is still here and so robust is indisputable testament to their care", "I've no worries that anyone would be unkind or abusive to [person]. There's some lovely people there."

Staff we spoke with demonstrated a good understanding of the people they were caring for and a genuine passion to support people to achieve their maximum potential. Some staff had worked with people for a number of years. For example, we saw one staff member had provided support to one person for 16 years and as a result had an in-depth knowledge of how to care for them. Staff had developed good relationships with people they were supporting and were able to give us examples of people's likes and dislikes and care needs and how they promoted people's independence. A staff member told us, "I like the work I do. I enjoy working with people and seeing them achieve. I've seen changes with one particular customer, seeing them blossom. It's brilliant to see that development, working through problems with people. People have got potential to be more independent and we need to allow them to self fail if need be." One person's relative told us, "The key worker is absolutely brilliant with [person], takes [person] out and [person] has lots of one to one time with [key worker]. I have lots of contact with [key worker]. [Key worker's] exceptional. I was with them one day when [person] had a seizure and [key worker] was so calm and collected, knew all [person's] drugs without having to refer to a piece of paper, timed the seizure. Text book. Wonderful."

A person centred approach to care and support was in place. For example, we saw people were able to get up and go to bed when they wanted and staff would respect people's decisions to stay up late into the night or not get up in the morning. A staff member also gave us an example of one person who had two different coloured toothbrushes and chose daily which one they preferred to use.

We saw evidence of people and their relatives being involved in planning their care. Where people did not have family members involved, we saw advocates were used where required.

We saw staff respected people's privacy and dignity and asked permission before supporting them with any

care. People told us staff respected their privacy. For example, one person told us, "I have a bell on my door and if they want to see me they come and ring the bell, they don't just walk in 'cos that wouldn't be right" and another said, "I have a doorbell on my flat and they ring it if they want to see me; it's good manners." Staff also gave us examples of how they would cover people if supporting with personal care and keep doors and curtains closed to protect people's dignity.

We saw a clear focus on encouraging people to be as independent as possible and plans of care reflected this with clear setting of goals. A staff member gave us an example of how the service had supported a couple to move to a more independent setting. Another staff member told us how they encouraged people to do more for themselves. They said, "If they want to go out shopping they make the shopping list, check in the fridge, identify in the supermarket what they want and I hand the phone to them for them to order a taxi back." A relative told us, "[Person's] able to express [themselves] and [person's] definitely encouraged to be independent with things like the cooking and washing." However, one staff member we spoke with told us they felt some staff could do more to promote choice and independence.

Another relative explained how the staff had worked with their relative to improve their hygiene and supported them to shop regularly for food. They said, "There was a time when [person] wasn't keeping [person's] clothes clean and would sometimes wear clothes that had been washed but weren't dry but that doesn't happen now. [Person's] always clean and dry and there always food in the fridge."

We looked at how the service worked within the principles of the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. We spoke about the protected characteristics of disability, race, religion and sexual orientation. For example, one member of staff talked about ensuring one person's religion was respected through observing correct hand washing routines and respecting their prayer routines. Another staff member talked about how the service had supported a couple with their relationship. Our discussions with staff showed a good understanding of how they needed to act to ensure discrimination was not a feature of the service.

Good

Is the service responsive?

Our findings

Care records were person centred with lots of clear information recorded on the person's life and history. Sections included information on managing risks, 'all about me', incidents and safeguarding, health, decision making, goals and aspirations, support and what the person expected from their key worker and/or social worker. Plans of care were presented in an easy read format to promote understanding and involvement of the person. It was clear that people living at the service were at the centre of their care and support.

Each support plan focused on helping people to achieve clear goals around improving their independence and social opportunities. For example, we saw one person had goals around financial independence, maintaining a healthy weight, activities and being more independent around the home by doing more cleaning, washing and cooking. Another person was being supported with their goal of planning and going on holiday. We saw goals were reviewed regularly and had a clear timescale for achievement.

We saw electronic care records were stored centrally with copies kept in people's homes. People we spoke with were aware of their care plans and we saw evidence of people's involvement in the planning of their care and goals. A relative commented, "[Person] has a care plan in place and they do keep us informed of what's going on."

We saw regular care reviews took place with people's family and members of the multi disciplinary team which could include people such as the person's social worker and the community learning disabilities team. One person told us, "I have a care plan, they talked to me about it but we don't need to change anything." A relative confirmed this, saying, "We have meetings about [person's] care from time to time but they keep me well informed in between times if there's anything I need to know."

People had access to a range of activities and social opportunities. We looked at people's care records and saw activity schedules were in place based on people's likes and preferences. For example, one person had held a barbeque to take advantage of recent warm weather and went on regular trips to a night club. One person we spoke with told us, "I chat to them all and go out one-to-one on Thursday, sometimes we go bowling." Another person commented, "If I tell them what I want to do they help me do it. Sometimes I want to go bowling or to the pictures; they organise it for me; they help me a lot." A family member said, "I think they provide ample activities for [person's] needs and I feel blessed that [person's] there." We saw some people worked in various locations during the day with some employed internally by Yorkshire Housing.

A system was in place to log, investigate and respond to complaints. The complaints procedure was on display in each supported living property in easy read format. We looked at how complaints were managed. We saw complaints were responded to appropriately and people we spoke with understood how to make a complaint. One person commented, "I have talked to the staff if there's something I want and they deal with it for me. Sometimes I complain and they sort it out." A relative also told us, "We did complain about something years ago and others had complained too and as a result a member of staff left so yes, I think

they do listen and respond to us." This showed the service took complaints seriously and responded accordingly although one relative commented they thought the service was sometimes more reactive to their comments rather than proactive.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with were all complementary about the service and told us they knew senior staff and some of the management team. Comments included, "I love it here", "I think it's a good place to live, the best place in my born life, the home is like paradise, I want to stay here for the rest of my days," and, "I know the manager, she's really nice. I like it here." We saw the registered manager knew people who lived at the supported living services by name and chatted in a relaxed manner with them during our visit to one of the premises.

We spoke with some relatives about the management of the service and received mixed responses. These included, "I don't think it's well led and it could be improved but that said my family member is happy there so that's the main thing", "I think the home is well managed now. The home is very happy with a nice cross section of staff. We feel [relative] has a wonderful rapport with the staff, all of them", "I don't think the home has been well run under Yorkshire housing. We are hoping that they will get out and someone who knows what they are doing and can do it better takes over", "I've always found them (management team) really easy to talk to. They'll ring me if there's any problems," and, "It used to be a lot better." Some relatives, particularly at the largest supported living premises commented on how they felt communication could be improved in relation to changes at the service and staff changes.

Staff provided mixed feedback about the support they received, morale, teamwork and how the service was managed. One staff member said, "Think it's a good place to work, lots of changes though. Any support we need we have got." However another staff member said, "Staff team are a bit divided, certain staff members make it uncomfortable, feel like we are a divided team, feel its impacted on residents as it's so chaotic," and another told us, "I think everyone is on edge because of the company being taken over. Some staff don't get on. The staff team is divided; there's a lot of tit-for-tat, some staff getting others into trouble." Other staff commented on how they felt favouritism was shown to some staff and how some staff did not, "Pull their weight." We saw these comments largely related to one of the supported living premises, the largest one. Other staff comments included concerns about the future of the service and how this had impacted upon staff morale. Many staff we spoke with felt communication and support about this could be improved.

These comments matched recent concerns we had received about the service, focusing on one particular location. A new management team had been put in place at the location including a new house manager and deputy manager.

A number of staff members told us they were optimistic the new management team would improve things with some saying they had already noticed improvements, such as the reintroduction of an eight am to 12 midday shift and clear duty allocations. Comments included, "Think [house manager's name] and [team leader's name] are changing things for the better. We need change and positive change," and, "I like the new team leader. [Team leader's name] is a real person centred person. Think [house manager] is going to get thing on track. Think she had a very common sense approach. I've no issues going to [team leader] or [house manager] if I have any concerns. We see [registered manager] quite regularly; I can speak quite candidly with him."

The registered manager was open and honest throughout the inspection process and it was clear the management team were enthusiastic, striving to improve the service and open to suggestions for further improvements. The registered manager told us, "We've been working extremely hard as a management team. I'm very proud of the work we've done."

Yorkshire Housing was currently working with the local authority to transition the Lifeworks services to other providers and this had caused some concerns among staff, people and relatives of people living at the services. We saw the service had discussed this at meetings although some staff told us they thought communication about this could be better.

A system of audits and checks was undertaken by the management team. This included care plan audits, finance audits and medicine audits. As the service was currently short of team leaders to undertake many of these audits, service managers and the quality officer were increasing the number of audits they were undertaking. We looked at these audits and saw they were effective in identifying areas for improvement. For example, we saw a medication workshop had been held to address some issues, the service had a 'medication work group' which met regularly to focus on continued improvements and the medication audit procedure compliance had increased to 95.2% since the quality officer had increased the audits. Senior managers also completed audits and put actions in place for team leaders to complete.

A monthly operations report was completed by each team leader and sent to senior management to provide information on how each property had been performing including details of any incidents or complaints. This helped to provide senior management with up-to-date information on events which had occurred within the service.

However, we saw a lack of organisation of complaints records with no central collation of these. This meant we were unable to establish how many complaints had been received in a set period such as the last three months, six months or a year. The collation of this information would help the provider to assess and monitor the quality of the service provided. We spoke with the registered manager who recognised improvements were needed in this area.

A continuous improvement plan was in place setting out how the service would develop over the next year. This demonstrated the service was committed to continuously improving the quality of its service.

A system was in place to record, investigate and learn from incidents and accidents. Incident forms were present at each property where people were supported. Completed forms were sent to the health and safety team where they were analysed to look for any trends.

Regular staff meetings were held. This included management and team meetings. Areas to improve the service were discussed such as medicines, safeguarding, customer outcomes and training. These were also a mechanism to provide support to staff. An annual staff survey was also completed to seek staff views on the service. This had been collated to see where improvements could be made.

Systems were in place to seek and act on people's feedback. At some properties resident meetings were held as well as family forums. A person living at one of the services told us, "We have meetings sometimes and we all talk about what to do. I think it's good. I like living here." Another commented, "I'm nicely looked after, we have meetings every month to talk about things." We looked at a sample of these meetings and saw topics such as menu planning, activities and general welfare were discussed. Smaller services held meetings on a one-to-one basis and all people received regular reviews where their feedback was used to make changes to the service and/or their care and support.

We saw the service fostered links with the wider community. For example, we saw the service had strong links with a local college, working with them and students on various projects and staff from a local bank had recently visited one of the services to work alongside people for the day.