Stockport Metropolitan Borough Council

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Inspection report

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Date of inspection visit:
09 August 2016
11 August 2016

Date of publication:
31 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an announced inspection of Stockport MBC Learning Disability Services on 9 and 11 August 2016. Following our site visit additional information was received and our inspection continued throughout October and November 2016.
We last inspected the service in August 2014. At that inspection we found the service was meeting all the regulations that we reviewed.

Stockport Metropolitan Borough Council provides care to people who live in supported tenancies and who require a range of support relating to their learning or physical disability, sensory impairment or mental health needs. A multi-agency health and social care team is built around the service to provide on-going support to meet the social care and health needs of the people supported by the service. The service is based in Stockport, Greater Manchester.
There was a registered manager in place. 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 manager was present during the inspection.
Following our site visit additional information was received in relation to referrals to health care services, restrictions on visits and how the service monitored and managed incidents and complaints. Further details about this can be found in the body of the report.

The people who used the service had a range of learning disabilities which meant we were unable to speak to all the people who used the service. However, those we did talk to were happy with the care they received. One person told us "I love it here, it's really nice. All the staff are kind".

Medicines were administered by staff who had been given appropriate training to ensure that they were given safely.

We saw that suitable arrangements were in place to help safeguard people from abuse, there was a safeguarding policy in place and all members of staff were aware of the whistle-blowing procedure.

The care records we looked at showed that where risks to people's health and well-being had been

identified appropriate plans had been put into place to minimise the risk of harm.

People were supported by sufficient numbers of suitably trained staff. We saw that recruitment procedures ensured staff had the appropriate qualities to protect the safety of people who used the service and we saw they received the training and support required to meet people's needs.

The staff we spoke with had an in- depth knowledge and understanding of the needs of the people they were looking after. We saw that staff provided respectful, kindly and caring attention to people who used the service. A visiting relative told us staff were approachable and would listen to any concerns, and respond appropriately.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs and preferences. People had detailed, individualised support plans in place which described all aspects of their support needs.

Where people who used the service did not have the capacity to make their own decisions, the service ensured that decisions taken were in line with the principles of the Mental Capacity Act 2005. Best interest decisions and any consultation undertaken were recorded as to why the decision was taken in the best interests of the person.

Where possible people were supported to do their own shopping for food and received help to prepare their meals. Care records showed that attention was paid to what people ate and drank, and where people had been assessed as having a risk associated with eating and drinking, such as choking, specialist assessment and advice was followed.

We saw that staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. They demonstrated a good understanding of the background and history of people who used the service and were able to help them to consider their future options.

Where people had difficulty communicating staff were patient listeners. They showed understanding of people's particular communication styles and how to interact positively with the people who used the service.

The care and support people received was reviewed on a regular basis and any people who had an interest in the person's well-being was invited to attend and comment. Where necessary the service would arrange for an advocate to represent the person's views on service delivery.

People were supported to pursue their hobbies and interests and had their own activity plan with a timetable of activities.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided and there were systems in place for receiving, handling and responding appropriately to complaints.

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 and there were appropriate procedures in place to protect people from abuse.

Where risk was identified detailed care plans were in place to minimise the risk of harm.

There were sufficient numbers of staff and procedures were in place to ensure the staff recruited had the appropriate qualities to protect the safety of people who used the service.

Medicines were administered by staff who had been given appropriate training to ensure that they were given safely.

Is the service effective?

Good

The service was effective.

Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

Staff received sufficient training to allow them to do their jobs effectively and safely and systems were in place to ensure staff received regular support and supervision.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, who contributed to care plans.

Is the service caring?

Good

The service was caring.

People received care from people who knew them well.

Care was person centred and staff supported people to express their views.

People's care records were stored securely so that their privacy and
confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

Detailed care plans indicated people's interests and activities and identified risks to people's health and well-being, and specialist guidance was included in care plans.

Person centred reviews were held on a regular basis.

People were supported to pursue their hobbies and interests.

Is the service well-led?

Good

The service was well led.

The service had a manager who was registered with the Care Quality Commission (CQC).
The provider had systems in place to monitor the quality of the service.
We saw that regular audits/checks were undertaken on all aspects of the running of the service.

Stockport Metropolitan Borough Council

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 announced inspection took place on 9 and 11 August 2016 and was carried out by two inspectors. We gave the provider 24 hours' notice of our inspection. This was because we wanted to be sure that we could visit people in their homes in order to talk with them about their experience of the service and to observe people's interactions with staff. Before the inspection, we reviewed all the information we held about the service. This included notifications about safeguarding, accidents and changes which the provider had told us about. At the time of our inspection, we had not requested a Provider Information Record (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 gathered this information from the provider during the inspection. We asked the provider to tell us what was working well and improvements they planned to make.

During our inspection, we were able to speak to four people who used the service, and a relative of another. We spoke with the registered manager, head of service, three team managers, a support worker supervisor and four support workers. We visited three tenancies, where we looked at how staff cared for and supported people. We also examined six care records and three medicine records, four staff recruitment records, the staff training plan and rota, and records about the management of the home. We also received some information about the service from the local Healthwatch.

Good

Our findings

When we spoke to people who used the service, they told us that they felt safe. One person said, "They look out for me here. I know I am safe" and the relative of another person who used the service told us "X is safe here. The staff know him well and his needs are met."

We saw that suitable arrangements were in place to help protect people from harm and abuse. The service had safeguarding policies and procedures which provided guidance on identifying and responding to the signs and allegations of abuse. One member of staff we spoke with was able to give a good account of the specific risks attached to vulnerable adults and the safeguards in place to minimise these risks. They recognised the environmental and behavioural factors which made people with learning disabilities vulnerable, including dangers posed by other people who used the service. There had been 15 safeguarding concerns raised in the past six months We saw that a record of allegations was kept, with full reports on investigations, outcomes and actions taken to protect people from harm.

All members of staff had access to the whistle-blowing procedure (the reporting of unsafe and/or poor practice). The registered manager informed us that all concerns raised under the whistle blowing policy were investigated by a senior member of staff not connected with the concern. This provided a level of independence and impartiality.

We looked at six records which showed that risks to people's health and well-being had been identified. For each person who used the service there were assessments for a variety of physical and environmental risks including behavioural risk and risks around lifestyle choices. Risk was measured against severity and likelihood, and if required a risk management plan was implemented and cross-referenced to support plans where applicable. For example, we saw that where a person was at risk of falls, their care plan identified steps to minimise risk including provision of fall detectors. We saw that these were in place. We also observed that other appropriate equipment such as frames and hoists were commonly used and regularly reviewed by a moving and handling co-ordinator. In another tenancy we saw that where a person had been identified as being at high risk of scalds and burns due to a tendency to touch items in the kitchen, the service had taken action to reduce the risk without restricting the person's opportunities to participate in general household duties by using equipment and modern adaptations such as plastic kettles and induction hobs which warm and cool more quickly.

We looked at how the service manages challenging behaviour and the restraint of people who used the service. Restraint is the act of restraining a person's liberty, preventing them from doing something they wish

to do. We were told that training is provided in "positive behaviour management". One person who had completed this training explained that this helps the staff to recognise when individuals may be getting distressed, and to look at more appropriate ways to help people meet get what they need. We observed this in practice; one person had become upset and agitated because a visit they were looking forward to failed to materialise. By using distraction techniques, allowing space and time for the individual to vent their feelings the individual was able to settle. Care staff supported this person with diligence and patience in a non-judgemental manner.

We were told that a number of staff in each team where people's behaviour had been identified as challenging had received training in safe removals, and identified staff had further training in behaviour and sitting restraint.

We looked at two staff files which showed procedures to ensure the staff recruited had the appropriate qualities to protect the safety of people who used the service. The files contained job descriptions, proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a medical questionnaire, a job description, references and interview notes. Pre-employment checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

When we spoke with staff they told us that they felt there were enough staff to meet the needs of the people who used the service. The service employs over 200 members of staff. The registered manager informed us that staff were allocated to work in specific tenancies, each with its own duty roster compiled according to the support needs and level of dependency of people who used the service and the specific skills of the staff, so staffing levels varied from tenancy to tenancy. We saw staff had time to work closely with people to assist them to meet their needs. As care staff would normally work within a specific team they were able to get to know the people who used the service well and could provide a consistent response to people's needs

We looked at the duty rosters in two tenancies and saw that on both there was a need to cover unallocated shifts, for example on one roster there were seven regular staff and one vacancy for a permanent member of staff. We were informed by the registered manager that where gaps were identified in advance the service operated a 'bureau' of casual workers who would be able to coordinate and arrange cover as required. We spoke to one bureau worker who told us they worked regularly at that tenancy and had got to know the people who lived there well. In addition, the service would offer overtime to staff to cover sickness or other staff shortages.

However, we were made aware of an issue where a member of staff had recently failed to turn up for a shift at a time when no alternative cover could be found, meaning that there was insufficient support to meet the identified needs for the whole of that shift. We spoke to the Head of Service about this and were informed this had been due to an administrative error, and whilst contingency arrangements were put in place and no harm occurred on this occasion, the service had since reviewed its on-call systems to ensure appropriate cover would be provided in the event of a future occurrence.

The registered manager informed us that care staff were employed to work for the whole service and could be called upon to work at any of the tenancies, for example, to cover sickness or annual leave. Prior to our inspection we were informed by an anonymous member of staff that support workers were being sent from their normal place of work to tenancies and people who used the service with whom they may be unfamiliar, sometimes at very short notice, and without appropriate supervision. This meant that there was a level of inconsistency in support and increased risk, for example, of medication errors or providing

inappropriate diet. The registered manager told us that some staff were, "dedicated, and continue to provide a good service," but that a number of staff had been employed for a long time in supported tenancies where the level of need was fairly low. They were resistant to moving into teams where they would be asked to support people with a high level of need, or lacked confidence to work with people whose behaviour was challenging. He informed us that appropriate training, monitoring and support was being offered to ensure that all staff were sufficiently competent and confident in their role.

The registered manager, team managers and assistant team managers operated a 24 hour on call service. Risk assessments were carried out to consider the effects of staff lone working and occupational stress in line with the service's lone working policy.

We looked to see how the medicines were managed. We checked the systems for the receipt, storage, administration and disposal of medicines. We also checked the medicine administration records (MARs) of three people who used the service. The MARs we looked at showed that staff accurately documented on the MAR when the medicine had been administered and taken by the person. This showed that people were given their medicines as prescribed; ensuring their health and well-being were protected.

At the three tenancies we looked at we found that medicines were stored securely. At one of the locations people who used the service lived in their own apartments, so medicines were stored in locked cupboards in their apartments, and case files indicated how to access the cupboard. Keeping medications separately decreased the risk of administering the medicines to the wrong person and also allowed for support to self-administer if practicable. We saw that medication was dispensed by people trained and assessed as competent, and we saw evidence that stocks were checked on a daily basis, with any surplus stock disposed of appropriately.

We saw that the system in place for the storing and recording of controlled drugs (very strong medicines that may be misused) was safe and managed in accordance with legal requirements.

Some people were prescribed medicines to be taken as required or 'PRN' e.g. paracetamol. We saw that close attention was paid to this type of medicine with records showing why it could be administered, the route (i.e. how it should be taken), the dose and the frequency. This allowed for better monitoring and review of any medicines given that were not required at all times. In some cases, where 'as required' medicine might be given, protocols established that the support worker would contact a manager to seek approval to administer the medicine. Notes would indicate the agreement had been authorised but the MAR records did not always state the reason for giving the medicine. Stating why an 'as required' medicine has been given would help to assess any underlying medical condition, and help to understand any behavioural issues which might be alleviated through other less intrusive methods.

The tenancies we looked at were all secure, and Team Managers would take responsibility for ensuring health and safety audits were carried out on a regular basis, including monthly fire drills at each tenancy, and yearly checks on water, gas and electrical appliances.

Good

Our findings

When we talked to staff they demonstrated an in depth knowledge and understanding of the needs of the people they were supporting. When we spoke to the people who used the service, they were complimentary about the staff and their ability to provide care and support. One told us, "You're looking at a different me now. The staff have helped me so much. I'm more confident and feel much better about myself".

The registered manager told us that when recruiting new staff the service don't ask for specific qualifications but expect applicants to have some experience of 'care' and seek candidates who can demonstrate evidence that they can meet the expected standards treating people with dignity and respect. Once recruited, new starters are given a full mandatory induction. The first week covers mandatory training in care. This is followed by a period working at specific tenancy under the supervision of an experienced support worker. This gives the new worker the opportunity to get to know the people who use the service. A probationary period of six months can be extended if required.

All new support workers are enrolled on the Care Certificate. This is a professional qualification which aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care.

Further ongoing training was available, and we looked at the training matrix which showed the service had provided training to over 75% of staff in 12 key areas in such areas as, safeguarding adults, first aid, medication, food hygiene, and clinical subjects such as epilepsy, autism, and positive behaviour management. One tenancy we looked at had recently admitted a person living with dementia, and it was recognised that not all staff had experience of this, so dementia training had been arranged for all staff.

Since January 2016 the local authority initiative to broaden the provider market has led to a service downsize. As people have left the service, care staff who have worked with specific people for a long time have been required to work with new people within the service who may present with different challenges. When we spoke to the registered manager about this he informed us that some staff have found this difficult, as they have been part of settled and longstanding staff teams; some support workers had been working in service for more than twenty years and working with the same groups of people for 15-20 years which has led to staff attachment and conflict. To overcome the challenges of an older staff team and a different service group, the service has completed a training needs analysis for each member of staff, and

this has helped to determine their skill set and requirements prior to consideration of which tenancy would be the most suitable environment for them. By providing training and support, coupled with supervision, regular team meetings and staff briefings, most staff have adapted to their new working conditions. One support worker we spoke to had recently moved to a new tenancy. They told us that they were initially apprehensive and unsure if they would be able to cope, but felt that they had sufficient support and backing to rise to their new challenge.

Staff we spoke with confirmed that they received regular supervision. Each tenancy had a support worker supervisor who would be responsible in part for ensuring that all support workers had a supervision session at least four times each year. In turn they were supervised by their Team Manager. In one tenancy we saw that there was a clear timetable setting out times and dates for individual supervision sessions with the support worker supervisor. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw risk assessments were made when any interventions might be restrictive, for example, where a person who used the service had a tendency to place items in their mouth, a full risk assessment showed that the least restrictive practices had been considered and implemented.

The staff we spoke to were well informed about the MCA, and we saw that capacity assessments were in place when we reviewed six care files, and best interest decisions were recorded including any consultation undertaken and a rationale for reaching the decision taken. We were informed that applications had been made to the Court of Protection to provide care and support for people who were unable to make decisions about their care and support and that two people were subject to Court of Protection decisions.

People had varying degrees of support needs ranging from mostly independent to requiring increased levels of support. Some people were able to plan and select their food choices with assistance from support workers. We saw that people had choice about what they wanted to eat. We saw that where possible people were supported to do their own shopping for food and received help to prepare their meals, and inspection of care records showed that attention was paid to what people ate and drank. Daily record sheets indicated the type and amount of food they had eaten.

Where people who used the service were unable to prepare their own meals we were told that food cooked by the staff was good and nutritious. One relative we spoke to told us, "they get good food, all fresh with a roast on Sundays. X has a good appetite, but doesn't go hungry". In two tenancies we visited, we saw that mealtimes were seen as an occasion for people who used the service to sit together around the table to eat their meals. Where people had been assessed as having a risk associated with eating and drinking, such as choking, people had received specialist assessment, and advice was followed.

The care records also showed that people had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, who contributed to care plans. We saw evidence in one care file of multi-disciplinary team meetings involving a Speech and Language Therapist (SALT)

physiotherapist and occupational therapist. Other care files showed attention was paid to general physical and mental well-being, including health action plan records which recorded weight checks; recorded regular, dental checks, and gender specific annual health checks

Good

Our findings

One support worker commented to us, "I have never worked with a more committed dedicated staff team. It is hard to put into words the level of care love and affection for these [people who use the service]. They come in and carry on in spite of the challenges working here". We saw that the culture of the service was very much geared to the needs of the people who used the service; positive regard was central to the delivery of care and support, and we observed good interpersonal relationships between staff and people who used the service.
People who used the service told us that they believed they were well cared for. One said to us "Everyone makes you feel so welcome. It's part of your family, they accept you for who you are".

People told us they thought the staff listened to what they had to say. One person told us, "I love it here. It's really nice. All the staff are kind and listen to all of us". We saw that staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. This was not confined to the 'here and now'; when we talked with support workers they were able to provide us with a good understanding of the background and history of people who used the service and were able to show consideration of their future needs. Care notes did, however, give good instruction to respond to the person, with sound advice on meeting need.

Concern and understanding of individuals was expressed by staff with empathy. This was reflected in the response of people who used the service, so for example, whilst talking of the care provided one person who used the service told us the person in the next apartment screams and shouts a lot "She can't speak like us; it's her way of communicating. They [The staff] give her lots of support and encouragement".

We saw that staff had developed a good rapport and understanding of the people who used the service and treated them and their belongings with respect. For example, when we asked to look at a care record the support worker first asked the person who used the service for permission to hand it over. Staff understood people's particular communication styles and how to interact positively with them. Where people had difficulty communicating staff remained patient and took time to listen, acknowledge what they were saying and respond appropriately. For example, we overheard a conversation between a person who used the service and a support worker where the former was trying to express a concern about his behaviour. The support worker listened and was able to reassure the person that the matter would be addressed appropriately. In each of the tenancies we visited, there was an open, relaxed and friendly atmosphere. Conversation between people and staff which was respectful and demonstrated a good understanding of the needs and interests of the people who used the service, such as a conversation about the upcoming

football fixtures with a keen soccer fan.

We saw that that people were encouraged to remain as independent as possible, and staff supported people to manage tasks within their capabilities, and we saw that the people who used the service enjoyed the responsibility this afforded.

People who shared the same accommodation were well matched, and consideration was given to their compatibility. We asked the registered manager how people were allocated to the different tenancies within the service. He told us that demand for accommodation for people with learning disabilities was high, and needs were discussed at an 'accommodation forum' which a member of the management team would attend. The service placed a high degree of emphasis on compatibility with other service users before determining suitability to move in to one of the properties.

A discussion with a team manager showed they were aware of how to access advocates for people, and informed us of the positive role one advocate had provided to support a person who used the service. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them. We saw evidence to show that the registered manager had recently requested an advocate for one of the people who used the service.

We were told the cultural and religious backgrounds of people were always respected, and when we talked with staff members they were able to demonstrate an understanding of the diverse needs of different cultures or religions. Whilst the training matrix showed equality and diversity training had been completed by less staff (67%) than any other formal training modules, the provider confirmed that staff training needs in this topic was ongoing.

We saw that all records and documents were kept securely in the staff offices, and were told that other houses and properties had a staff room were records were stored. This ensured that confidentiality of information was maintained.

There was a recognition at Stockport learning disability services that people who used the service were aging and in some instances we saw that plans for end of life care had been considered, and some staff had completing training in the Six Steps end of life care pathway. This is a programme of learning for care staff to develop awareness and knowledge of end of life care. We were told that where a person had recently been diagnosed with a terminal illness the service had drawn up a support plan to consider how best to meet their needs, wishes and the consequences that her passing may have on other people close to the person. This included liaison with MacMillan nurses, best interest meetings, an additional training for support workers to administer a high quality level of care.

Good

Our findings

People who used the service and their relatives told us that the service was responsive and met their needs. A relative told us "The staff here are fantastic. They go above and beyond." They told us that the staff were all approachable and would listen to any comments or suggestions, and, "They will sort out any problems, they are always obliging".

The registered manager told us that detailed assessments were undertaken by a senior member of staff before a person was admitted to the service. Referrals were taken from the local authority accommodation forum. In addition, the service had a short-term assessment unit which provides intensive support to up to six people for people where they would receive support for up to a year to develop their skills and be supported in seeking further accommodation. Full and comprehensive assessments would be completed and plans put in place to find a suitable tenancy within the service. At the time of our inspection there were five people in the assessment unit. We reviewed the notes for one of these people and saw that detailed plans had been drawn up to support this person, and plans had progressed to seek a placement in their own tenancy supported by the care staff within the service. Consideration of social skills and interactions was given a high priority along with physical and mental health needs, and detailed plans had been drawn up to support the next stage of intervention.

We looked at six care records. These contained information about each person which was comprehensive and contained sufficient detail to guide staff on the care and support to be provided. Care plans covered community needs, leisure, and communication providing detailed instruction to support the person with specific tasks, such as 'going for a walk' or 'withdrawing money from the bank' broken down into specific tasks. Care plans demonstrated a good understanding of the person, for example, in one plan we looked at, a comment stated "will sniff hair or touch face. This is [their] way of interacting and should not be discouraged".

They also showed that risks to people's health and well-being had been identified, such as mobility, physical health/ mental health and self-administering medication. Plans were thorough and provided a high level of detail. Staff wrote down in care plans what action they would need to take to reduce or eliminate any identified risk. These were detailed, for example, we saw one record which stated how a person's mood could affect behaviour: "On a good day XX will be compliant. On a bad day XX may spit medication out and refuse to swallow. Staff must follow the medication procedure and report to on call manager".

We saw that specific specialist information and guidance from the relevant professionals involved in their

care, such as physiotherapists, was contained within the care records.

We asked a support worker about the goals of the service and they told us the aim was to promote people's independence as much as possible. They were able to demonstrate this by showing us some care records for a person who had been in the service for a number of years. This showed that the more challenging behaviours exhibited when the person was first brought in to the service had reduced in levels and frequency as staff had got to know, interpret and understand the behaviours. Case notes included observation charts for newly exhibited behaviours which allowed staff to understand and interpret the person's responses, either positive or negative, to new experiences.

Care records were reviewed to ensure the information was fully reflective of the person's current support needs, and when any changes were made all regular staff were asked to sign to say that they had taken account of the changes. If staff are unaware of any changes, this could increase the risk of improper care being delivered.

We saw from case notes that a full person centred review was held every six months, involving the person who used the service where they had the capacity to be involved in the planning of their care. Family members or advocates would be invited, as well as staff from the tenancy, and if the person had a social worker involved in their case, they would also be asked to attend. Where issues were identified this was noted and follow up action was recorded. For example in one review we looked at, we saw that the use of unfamiliar staff was identified as a concern. Following the review an agreement was reached for the support work supervisor to make direct contact with bank workers who were familiar with the tenancy rather than going through the normal channel of requesting cover through the services 'Bureau'. This meant that there was a greater level of control over the staff who would work at the tenancy.

We saw that the service responded to day-to-day issues and was flexible in routine where this was appropriate. For example, where people who used the service would normally attend further education or college classes during the term time, extra staff were available over the holiday periods to ensure continuity of care and access to leisure pursuits was maintained for all the people who used the service.

We saw that people were encouraged to take part in activities and supported to find meaningful occupation. Where possible people who used the service were supported to find employment or training and a large number of people who used the service had access to day services in the community. We spoke to one person who had been support to access paid employment working in a supermarket. Where people had hobbies or interests they were supported in this. One person we spoke to was a keen photographer and proudly showed us some of the photographs he had entered into photography competitions. The photographs were of an exceptionally high standard and received awards.

At one tenancy we saw that there was a detailed individualised activity plan for the people who used the service on display on a noticeboard. This covered a number of leisure and learning activities, with different pursuits each day. However, this was not displayed in a picture format, which meant that people who had difficulty with reading may not be able to interpret the activity on offer. Common activities included walks, swimming or attending local amenities such as 'Jump Nation (trampoline) or the Chill Factor (snow and ice activities).
We received information from the family of a person who used the service, in relation to conditions imposed on how the family communicated concerns to the service and restrictions on visiting. The service clarified that the protocol for communicating concerns had been introduced to enable the service to provide a consistent and comprehensive response to concerns and complaints received. The service also explained that the intention of the protocol was not to impose any restrictions on visits and apologised to the family

for any misunderstanding.

We looked at how the service managed complaints. The registered manager told us that complaints were generally dealt with through the local authority complaints procedure; all complaints were logged centrally and allocated to a senior member of staff to investigate. These would be monitored by a Quality Manager and records kept of actions taken. We are aware that the service is currently managing an on-going complaint, which is being dealt with.
One of the people who used the service was aware of how to complain and informed us that they had made an official complaint which they felt was handled appropriately. They were informed of the investigation and the eventual outcome. They were happy that the complaint had been treated appropriately and reached a satisfactory conclusion.

We saw that the registered manager kept a computerised log of any complaints made and the action taken to resolve the issues. However, whilst we were informed that a number of complaints made had not been resolved to the satisfaction of the complainants we were satisfied that the policy in place allowed for a full investigation and all complaints were taken seriously. The policy allows complaints to be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome..

Where possible, action was taken from complaints to improve the quality of service delivery.
The registered manager recognised that not all complaints could be dealt with satisfactorily and he accepted that positive criticism can be a helpful way to ensure a good standard of care was maintained.
The registered manager told us about the plans to support people throughout the service downsize. He informed us that as services are identified for transition any concerns are discussed with the people who use the service with their family members present, and separate meetings for families to explain the process. Independent advocacy services are provided to people who do not have anyone to represent their views, and staff work alongside the new providers prior to them taking over the service provision.

Good

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Stockport MBC Learning Disability Services is registered with the Care Quality Commission (CQC). When we visited, the service had a registered manager who has recently registered with CQC. The registered manager was present during the inspection.

Discussions with the registered manager and staff showed they had a good understanding of the aims and objectives of the service. The registered manager told us they wanted to ensure that people lived the best lives they can.

The service is modernising the way in which the Stockport adult learning disability service is delivered and monitored for people who use the service.
The registered manager told us that he wants to make sure that people who use services have as much control and choice about the services they receive as possible through high quality support using person centred approaches based on what is important to people and which are designed to help them to achieve their desired outcomes.
There was a clear management structure in place and staff were aware of their roles and responsibilities. To support the registered manager the service was divided into four divisions each with a Team Manager. Staff spoke positively about the registered manager and their team manager and they enjoyed their work. They told us they felt management responded well to the needs of staff and of the people who used the service and one person told us this encouraged teamwork and a good team ethos: "We work as a team, and are adaptable to the needs of people. [Staff] respond very well to the circumstances and work together. At the end of a shift, people will stay a bit longer to make sure everything is covered." They knew what was expected of them and understood their role in ensuring people received the support they required and their responsibility to provide this in a caring way.

Meetings were also held with people who used the service and their representative or relatives. They were given an opportunity to say what they liked about the service but also what, if any, improvements could be made. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution.

We looked at the systems which were in place to monitor the quality of the service to ensure people received safe and effective care. We saw that regular audits/checks were undertaken on all aspects of the running of the service and team managers would regularly review the service delivery at each of the tenancies. We saw evidence of recent audits on challenging behaviour, reporting systems, accident reporting and all risk

assessments. We saw that regular checks were made on the physical environment of each tenancy. These included checks on floors, stairs, lighting, ventilation and windows. These showed where improvements were needed and what action had been taken to address any identified issues.

Accidents and incidents were recorded and had been regularly monitored by a group of senior staff to ensure any trends were identified. We were told that there had been no identifiable patterns in the last 12 months. Similarly, any safeguarding alerts were recorded and checked for any patterns which might emerge.

The service placed a high emphasis on communication. In addition to individual supervision, we saw that there was a schedule for team meetings and staff briefings. Team leaders meetings were scheduled every month, and this would be followed by House Staff Meetings. Staff we spoke with confirmed that this information was correct. Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service. We saw the staff meeting minutes for one tenancy where discussions included the service users, household matters, training and activities. We saw staff meeting minutes also showed quality and safety were discussed on a regular basis.

We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.