L&Q Living Limited

East Living - Domiciliary Care Service

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

East Living Domiciliary Care Service provides care and support to people living in four 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

This inspection took place on 5 and 12 December 2017 and was announced. The provider was given at least 48 hours' notice because the location provides a supported living service for people who are often out during the day. At the previous inspection in October 2016, the service was rated as Requires Improvement with no breaches. At the last inspection the service was providing personal care support to 77 people in supported living schemes for adults with learning disabilities and extra-care and sheltered housing schemes for older adults. Since the last inspection the service had changed its model of care and now was providing support to nine people living in supported living schemes for adults with learning disabilities.

There were two registered managers at 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.

People who used the service, relatives and health professionals were complimentary about the standard of support provided. The locality manager involved families and other agencies to ensure people received the support they needed to express their views and make decisions that were in their best interests. Relatives and professionals were very positive about the service people received. The service specialised in supporting adults with behavioural problems.

Positive risk taking was driven through the safe use of innovative and pioneering technology in order to support people to live fulfilling lives. The registered managers and staff had an excellent understanding of managing risks and supported people that had previously challenged services to reach their full potential. The service was seen to constantly adapt and strive to ensure people who used the service were able to achieve their full potential. Over a period of time we saw that people were supported to progress and their support plans and environment adapted and developed to promote their independence.

The service had developed and sustained effective links with professionals and this helped them have a multidisciplinary approach in supporting people. Their success in achieving positive outcomes for people and their ability to develop best practice led to them being asked to share their ideas with other organisations that supported people with learning disabilities. This meant the service was being an excellent role model for other services.

People's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans were in place to monitor and reduce risks. People had access to

relevant health professionals when they needed them. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Medicines were stored and administered safely.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is legislation protecting people who are unable to make decisions for themselves. We saw people were able to choose what they ate and drank.

People had access to a wide variety of activities within the community. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered managers were approachable and open. The service had various quality assurance and monitoring mechanisms in place so the voices of staff, people and their relatives were heard and acted on to shape 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. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were recorded and administered safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

Is the service effective?

Outstanding

The service was outstanding in ensuring people received effective support. Positive risk taking was driven throughout the service using innovative and pioneering technology in order to support people to live safe and fulfilling lives.

Staff undertook regular training and had one to one supervision meetings.

The provider met the requirements of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected.

People were supported to eat and drink sufficient amounts and eat nutritious meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and to access health care services and professionals when they needed them.

Is the service caring?

Good

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint if they were unhappy about the service and felt confident their concerns would be dealt with appropriately.

People's cultural and religious needs were respected. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service well-led?

Outstanding

The service was well-led. The culture of the service was positive, person centred and forward thinking. The feedback we received from a professional, relatives and staff was that they all felt this service improved people's lives.

With the support of the locality manager staff supported people to overcome significant barriers and achieved positive outcomes in their lives. The approach and ethos of the service was clearly communicated to everyone involved with the service by the locality manager.

The service had developed and sustained effective links with professionals and this helped them have a multidisciplinary approach in supporting people. Their success in achieving positive outcomes for people and their ability to develop best practice led to them being asked to share their ideas to other organisations that supported people with learning disabilities.

Staff told us the service had an open and inclusive atmosphere and the registered managers were approachable and open. The service had various quality assurance and monitoring mechanisms in place.

East Living - Domiciliary Care Service

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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, the local borough safeguarding team, and a learning disabilities liaison nurse that provided services to the home. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 5 and 12 December 2017 and was announced. The provider was given at least 48 hours' notice because the location provides a supported living service for people who are often out during the day. We needed to be sure that someone would be in to assist with the inspection process. The inspection team consisted of one inspector and a clinical psychologist.

During our inspection we spoke with two people who are supported in individual flats which are owned by a housing association. We also spoke with one relative during the inspection. After the inspection we spoke with three relatives. The service had two registered managers in place. One registered manager was the complex needs manager and the other registered manager was the locality manager for the service. We spoke with the complex needs manager, the locality manager, the clinical lead, the HR business partner, one senior support worker, three support workers and one personal assistant for a person who used the service. A personal assistant is a support worker paid through a personal budget. We looked at five care files, staff

duty rosters, five staff files which included supervision records and two recruitment records, a range of audits, minutes for various meetings, medicines records, accidents and incidents, training information, policies and procedures, and safeguarding information.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person told us, "House feels safe." A relative when asked if the service was safe said, "I believe so. [Relative] knows the staff and he can talk to them. That gives me reassurance."

There was a safeguarding policy in place which made it clear the responsibility for the provider to report any allegations of abuse to the local authority and the Care Quality Commission. Records showed staff had completed training in safeguarding adults. One member of staff said, "You would go to the line manager. If they did nothing you would go to social services and CQC." Another staff member said, "We have to report it to the manager. We are here for [people who used the service] safety." The service had a whistleblowing procedure in place and staff were aware of their rights and responsibilities with regard to whistleblowing. The provider also held a safeguarding theme of the month in March 2017 where staff had a safeguarding themed supervision and the provider held events across the schemes to promote safeguarding to people who used the services. This meant the provider ensured people were protected from avoidable harm and abuse.

The complex needs manager told us and we saw records that showed there had been two safeguarding incidents since the last inspection. The complex needs manager was able to describe the actions they had taken when the incidents had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

People living in schemes had a range of risk assessments to inform staff about the risks people faced and how to mitigate against them. Risk assessments covered areas such as mental health, mobility, home environment, substance misuse, aggression and violence, physical risks, financial, accessing the community, cooking and falls. The risk assessments were specific to the individual need and included information for staff on how to manage risks safely. The service also had detailed positive behaviour support plans in place in line with best practice for supporting people who present with behaviour which can challenge. A positive behaviours support plan provides staff with a step by step guide to making sure the person not only has a good quality of life but also enables staff to identify when they need to intervene to prevent an episode of challenging behaviour. The level of detail provided to staff on how to support people to manage risks was high. For example, one person was at risk of becoming anxious during certain situations. The plan stated, "I feel better when staff sit and talk to me one to one, it shows that I have all their attention and that they are listening to me and my concerns. If staff do this and then tell me that they have spoken about it three times and will not talk about it again I stop being repetitive and getting more anxious about the things I am worried about." This meant the risk assessment processes were effective at keeping people safe from avoidable harm.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded. There was a requirement for staff to report events as they happened to a senior staff member who

analysed the situation and took appropriate emergency action if it was needed. For example, one person in the community had refused to get off public transport and the police had been called. The service had responded by putting new guidelines in place for the person when travelling on public transport and these new guidelines were shared in the next staff meeting. Since the guidelines had been put in place there had not been anymore incidents for that person using public transport. This meant that positive lessons were learned from any incidents or accidents related to an individual which were then implemented to improve the overall service to benefit everybody and protect people from the risk of harm.

The service supported some people to manage their finances. Transactions were signed by two members of staff. Financial records were checked at daily handovers and a weekly check was completed by a senior member of staff. Records confirmed this. This minimised the chances of financial abuse occurring.

The provider had a central recruitment team who managed the recruitment process for new staff. Scheme managers submitted requests for recruitment to the team who then managed the process centrally. Following an initial application form submission candidates were invited to interview. Records showed the interview process was values based and completed by at least two managers who scored candidates based on their answers. The provider had introduced literacy and numeracy assessments to ensure that staff had the skills required to perform their roles. The provider had also introduced further assessment of candidates to ensure they had the attitudes and behaviours the provider wanted to see in staff. Following a successful interview the provider used an external company to collect references and check employment history details provided. The service ensured that staff had completed an up to date criminal records check to ensure they were suitable to work in a care setting. The provider had a robust process in place to risk assess where potential staff had criminal records on their disclosure. The provider completed checks to ensure staff had the right to work in the UK including checks of applicants' identity. This meant the service had ensured they had recruited suitable staff.

Through our discussions with the registered managers, staff, relatives and people who used the service, we found there was enough staff to meet the needs of people who used the service. Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. One relative told us, "The staff is more stable recently. It's the same staff. It's a positive impact. They have more staff when they take [people] out." Another relative said, "Always someone there." However one staff member told us it would be good to have a standby staff member available at times.

People were supported by staff to take their medicines. Records showed staff were trained in how to administer medicines in a safe way. People had detailed medicines care plans which contained details of the medicines they had been prescribed, their purpose and how to support the person to take them safely. People who required PRN medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. Records showed that people had been supported to take their medicines as prescribed. Records also showed staff completed regular audits of medicines stocks to ensure that people had received their medicines safely.

Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control which covered such topics as hand hygiene, personal protective equipment (PPE), cleaning material and equipment and waste management. Records showed infection control had been recently discussed in the staff meeting for September 2017. The complex needs manager told us and showed us records of a quarterly audit which included checks on hand hygiene, PPE, disposal of waste, and the environment. Staff had access to personal protective equipment. One staff member told us, "We have aprons. Everything is here. We don't run out."

Outstanding ☆

Is the service effective?

Our findings

People who used the service and their relatives told us they were supported by staff that had the skills to meet their needs. One person said, "They [staff] talk to us." One relative told us, "The carers do a lot for [relative]. They are excellent. They look after her so well."

The service worked in partnership with other organisations and kept up to date with new research and development with evidence-based techniques and technologies to support people with the delivery of high-quality care and person centred support. The service worked with an organisation that provided assistive technology with light touch monitoring for people. This technology enabled people to become more independent whilst managing the risk to that person. The schemes had installed a range of sensors which gave insight into people's behaviours and promoted positive risk taking. For example, one person was receiving 24 hour support however with the sensors this person had allocated hours each week where they were independent whilst being lightly monitored from an adjoining location. By monitoring from an adjoining location it gave the person freedom to move about their home safely and with privacy. The service monitored the behaviours of this person and over time this showed they were becoming more independent with making drinks and snacks, and listening to the radio. This person told us, "I learn things." One relative told us, "They [provider] spoke to us about monitoring movement. They asked our permission. [Relative] has got more freedom to move about." The locality manager said, "Nice to see the difference in [person]. She would never have had the opportunities before. She leads a normal life in that time." The service also used the information from the sensors to plan people's support plans, in accordance with their needs and wishes. Through the use of the technology with the light touch monitoring this person had grown in independence with their life skills and now had a part time employment. The service had produced a report with Skills for Care which gave examples where people's challenging behaviours had decreased because of the work with the sensor monitoring. Skills for Care and Development is the sector skills council for people working in early years, children and young people's services, and those working in social work and social care for adults and children in the UK.

The service also used technology to support people with day to day tasks. Technology used was an interactive resource consisting of step by step life skill task videos presented on an application on a smart device such as a phone or tablet. Near Field Communication (NFC) tags were place around people's living space such as in the kitchen and bathroom. NFC tags can be small stickers, which contain a small unpowered NFC chip. Depending on how the tag is programmed, it can change various settings, launch apps and perform certain actions just by holding your smart device close to it. People could scan their smart device and a video was played to help them with such tasks as making a sandwich, brushing their teeth and doing their laundry. The locality manager told us the NFC tags had been used successfully in two of the four schemes with people using the videos to help with day to day tasks. The locality manager told us they did a presentation at the local authority celebration day where other providers were interested in using the NFC tag technology. A relative told us, "[Relative's] speech is getting better. She does her own washing. She has improved one hundred percent. She's come such a long way." This meant the service encouraged the safe use of innovative and pioneering approaches to care and support for people.

Staff told us they received the training they needed to perform their roles. One member of staff said, "I think it is good. You get online training and also face to face training where you get to ask questions. You choose and book training relevant to your work. We do get a lot of training related to our job." Another member of staff said, "It's very good because it helps me do my job effectively." Records showed that training opportunities were cascaded to staff by email who could then book themselves onto required training courses.

Records showed staff completed a range of training courses appropriate for their roles including, dignity, equality and diversity, person centred care, fluids and nutrition, communicating with people with learning disabilities, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safeguarding adults, fire safety, positive behaviour support and non-restrictive practice, basic life support, infection control, medicines, risk assessments, moving and handling, food hygiene, autism and support planning. New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. When new staff joined the service they completed a comprehensive induction programme which included a week of shadowing more experienced staff. One relative said, "They introduce new staff members gradually [to people] so they learn behaviours of that person."

The provider had a system where staff could apply for funding for specialist external training. The locality manager had utilised this scheme in order to complete a master's degree in positive behaviour support (PBS) through a leading organisation in the field. Records showed the knowledge and skills acquired through this course were still being applied on a daily basis in the service. The locality manager was also using her knowledge in PBS as a lead for a PBS group for the local authority and the clinical commissioning group. The locality manager told us the provider had supported her to start an external training course in management which included allocated days off to study.

There was an effective supervision and appraisal system in place. Staff told us they were provided with one to one supervisions. The supervision sessions enabled staff to discuss their training and development needs. We saw records of supervision during the inspection and noted areas such as people's safety and wellbeing were regularly discussed. Staff were supervised monthly. Areas discussed were key working, support plans and risk assessments, accident and incidents, safeguarding, medicines, health and safety, themed months which included black history month, and training. One staff member told us, "We have regular supervisions and appraisals." Another staff member said, "Supervision is about how we feel, if any issues, personal development, and things like that."

People were supported to have meals of their choice. One person said, "Someone cooks for me. The food is nice." A relative told us, "They seem to have a healthy diet. They are encouraged to use their own recipes." On the day of the inspection we saw people cooking their own lunch with support from staff. Support plans detailed people's dietary requirements and preferences and gave staff clear directions on how to support them. For example, one support plan stated, "I do not understand the link between my diet and health and require full support to maintain a healthy, balanced diet. I also find it difficult to leave food on my plate, even when I am full. Staff must support me with portion sizes, as well as amounts of sugar and salt I put in my food. I am able to make small meals, such as buttered toast, cornflakes or a cup of tea with minimal support."

People were supported to maintain good health. Each person had a health action plan. A health action plan is something the Government said that people with a learning disability should have. It helps people to make sure that the service had thought about people's health and that their health needs were being met. One person told us, "I go to the optician for new glasses." Another person said, "Sometimes I see the doctor."

One relative said, "[Relative] sees doctor and dentist. [Staff] take her." Another relative told us, "Staff members are aware of everything. They know [relative's] medical history. They deal with it straight away." People had a 'Hospital Passport', which was a document in their care file that gave essential medical and care information, and was sent with the person if they required admission or treatment in hospital. A health professional told us, "[Staff] have exhibited the ability to immediately flag up health concerns to me, so that the best care can be facilitated." This meant that people were supported to maintain their health.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

We found that staff and the registered managers were monitoring each individual for any capacity issues and where a decision had to be made for the person, this was done following a best interest process and involving people close to the person who knew them well and acted as their advocate. Records showed where people had legally appointed decision makers. One staff member told us, "You have to ask for everything. Whatever they want. It goes back to choice." A relative said, "[Relative] has the ability to do what he wants to do." Another relative told us, "They [staff] give [relative] freedom." That meant the service followed best practice in order to support people to make decisions, act in people's best interests and protect people's rights.

Each person had been assessed and restrictions to their freedom or choice were closely monitored. We saw that as a result of effective teamwork and innovative technology people became more confident and independent enough to enable them to have some restrictions removed and their support had been reassessed. For example, we saw that a person used to require support from staff members at all times. The consistent staff approach and technology being used had increased their confidence and independence meaning they now only needed support at certain times. Staff had worked with the person to develop and follow their preferred routine. This had given the person more independence and was less intrusive for them.

Good

Is the service caring?

Our findings

People and their relatives told us they were well treated and the staff were caring. One person told us, "Been here a long time. It's nice." One relative commented, "I do believe they [staff] are caring. They talk about [relative] as if they are close." Another relative said, "I think they [staff] are caring. They know [relative's] habits." A third relative told us, "[Relative] gets good care." A health professional said, "I have found that there has been compassion and a caring attitude expressed by the staff team."

Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said, "My relationship is professional with boundaries but we are close. There is a relationship that builds." Another staff member told us, "They [people who used the service] are lovely. I love it. I enjoy working with them."

Staff knew the needs and preferences of the people they were caring for and supporting. Each person using the service had an assigned key worker. A key worker is a staff member who is responsible for overseeing the care a person received and liaised with professionals or representatives involved in the person's life. Staff were able to tell us about people's life histories, their interests and their preferences. One staff member said about key working, "You have to communicate with [person] on her level. Cooking with her and talking to her is a key working session. I call family and keep in touch with them." Another staff member said, "I contact the family and friends and facilitate activities." Relatives we spoke with knew the keyworkers for their relatives. One relative told us, "[Relative] has a key worker called [staff member]. If I raise something [staff member] will get back to me." Another relative said, "[Relative's] keyworker is [staff member]. She keeps me informed." Records confirmed key working sessions were being regularly completed.

People and their relatives were actively involved in making decisions about the care and support provided. Care plans were reviewed regularly with input from people and their relatives. Records confirmed this. One relative told us, "I do get calls to review the support plan. It's about once a year. [Relative] is present. The care plan is embedded. We will say what we think. I do have an opportunity to say things." Another relative said, "I am having a meeting soon about [relative's] plan. It's at least twice a year. Normally with key worker and manager. If any changes we come to an agreement." A health professional told us, "[The service] conduct their own internal reviews, which I and the family are invited to, where [we] review of all current risk assessment plans."

People's privacy and dignity were respected. Staff we spoke with gave examples how they respect people's privacy. One staff member told us, "This is [person's] home. She can do what she wants. To go into her room we have to get her permission. She has privacy." Another staff member said, "It's [person's] home. Has his rights to do what he wants. You knock [on person's door] and if he answers you go in." A relative said, "[Relative] does have a choice."

People's independence was encouraged. Staff gave examples how they involved people with domestic tasks and doing certain aspects of their personal care to help become more independent. This was reflected in the support plans for people. For example, one support plan stated, "I can dress myself without support.

Occasionally I may need assistance on weather appropriate clothing." One staff member told us, "I am [supporting] [person] to take her to corner shop to buy what she wants. We give her money and she pays for it." This was reflected in that person's support plan.

Good

Is the service responsive?

Our findings

People told us they enjoyed the service provided. Relatives felt the care and support was responsive to their relative's needs. One person told us, "They [staff] talk to us." A relative said, "They [staff] are on top of things."

Support plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. The support plans covered what motivates the person, things that want to do now or change now, how to be safe, emotional and mental health, family and friends, living skills, finances, physical health, working, learning, and leisure. The support plans were person centred and focussed on what the person wanted to achieve in their life. For example, one person had wanted to get a job and records showed how that person was supported to achieve this. The person told us they now had a job. Staff were provided with step by step instructions on how to support people from greeting them through waking up, all stages of personal care and activities for the day. One support plan stated, "I usually wake up between 5am and 6am. You will usually hear me talk to myself when I am awake. Staff will need to wake me if I am still asleep at 6:30am. I will usually give myself a 20 minute countdown and get up when I am ready. Prompt me to get dressed and to [make] my bed. Give me my iPad. I will usually go back to bed and stay there for about an hour before I come down for breakfast."

People's care and support was planned proactively with them, the people who mattered to them and health and social care professionals involved in their care. Relatives were fully involved, where appropriate, in identifying people's individual needs, wishes and choices and how these should be met. They were also involved in regular reviews of each person's care plan to make sure they were up to date. Detailed support plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

The service understood the needs of different people and groups of people, and delivered care and support in a way that met the needs and promoted equality. Records showed people visited their place of worship. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The locality manager told us, "It would be important to get support from the [LGBT] community. [We] make use of themed months. We had a [equality and diversity] month. Staff need to be a positive role model." The complex needs manager said, "We have had specific training in [equality and diversity]. We always ask the question in the recruitment [interview] about [LBGT]. We like to gauge their thoughts and feelings." One staff member said, "Everyone has equality rights with religion and sexuality. We are here to support them." Another staff member told us, "You have to cater for their needs. You have to respect them and facilitate their choices. They have the same rights as anyone else." Training records showed staff had completed equality and diversity training. The service had a policy on equality and diversity available to staff. The service also held a themed month on equality and diversity in December 2017 which included an event open to people who used the services that talked about religion, race, sexuality and culture. The meant the service went the extra mile to address people's needs in relation to protected characteristics. The Equality Act covers the same groups that were protected by existing equality legislation which includes age,

disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. These are now called `protected characteristics´.

Relatives and staff told us that diverse activity programs were available to people depending on their interest. Each person's day was planned around their preferences. We saw that one person had started paid work. This person told us, "I got a job. I like the job." The same person told us, "I went to the gym today." Another person said, "Always something to do. Going to music. I play the drum." Relatives we spoke with told us people had choices of activities that were meaningful to them. One relative said, "It's a good routine there. Goes out for a weekly shop. [Relative] goes to day care four days a week. They take him out bowling and meal out." Another relative said, "[Relative] has a wide variety of things to do. [Relative] has a job at the moment." A third relative told us, "[Relative] goes on holiday. They take her shopping and to the pub." People were supported to choose activities of their choice. One staff member said, "We use visual stuff. [Person] had to choose some activities. Had to explain to him with pictures of the activity with a thumbs up or thumbs down."

The provider ran a range of activities and schemes for people who lived in all their services, both those included in the provision of personal care and other housing schemes. These had included a sports day, gardening club, baking competition, computer skills course, budgeting course, and exercise classes. We saw in the provider's newsletter pictures of people using the service attending the sports day and baking competition. This meant the service had gone the extra mile to accommodate activities for people so people could live as full life as possible.

The provider had a central complaints process for formal complaints. The complex needs manager told us there had been no formal complaints since the last inspection. They also told us they had received five informal complaints which had been recorded. Records showed the five informal complaints logged had details about the complaint, the date it was resolved and any follow up action. For example, one complaint was about the attitude of one staff member. Records showed the registered manager had called the relative to speak about the concern and the staff member had a supervision session about the incident. One person told us when asked about making a complaint, "I would tell people. Tell [complex needs manager]." A relative said, "Any complaints [locality manager] deals with it." Another relative told us, "I would contact the manager. I have the number." A third relative said, "I would tell [key worker] or her boss."

At the time of our inspection the service did not have any people receiving end of life care. The service had an end of life policy called "Dignity in Death and End of Life Care Policy" which was appropriate for people who used the service. Each person had a booklet about their health called "My Health Matters." The booklet had a section called "How I feel about death and dying." The section covered what relatives and friends the person would want to be involved if they were at end of life and also funeral arrangements.

Outstanding ☆

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well managed and they spoke positively about the locality manager. One person said, "[Locality manager] is nice." Another person told us, "[Locality manager] [is] someone to talk to." A relative said, "[Locality manager] is a good manager. Deals with people's concerns and deals with everything." Another relative told us, "[Locality manager] is good. She manages [people] well."

With the support of the locality manager staff supported people to overcome significant barriers and achieved positive outcomes in their lives. The approach and ethos of the service was clearly communicated to everyone involved with the service by the locality manager. One staff member told us, "She's good and a good listener. You are given an opportunity to get personal development. She is good at facilitating choice for people." Another staff member said, "She is lovely and down to earth. Good listener and very approachable. Always ready to talk to you." Staff were also positive about the support from the complex needs manager. One staff member said, "He is lovely and always there to help. Said I can call day or night. Good to have someone who cares." The locality manager told us, "He's good. He pushed me to do all things with confidence."

People`s needs were well known to the locality manager. They were involved in each person's support from the initial assessment throughout regular support and review meetings. They told us with passion and in detail about every person's care and positive outcomes they were achieving. They had a clear vision about what person centred support meant for each person and they were skilled in sharing their passion, commitment and vision to the support staff. The locality manager told us her biggest success was, "The change of the individuals in the last six and half years and their quality of life. It's rewarding to go into a scheme and see normal life happening." The locality manager had led on positive behavioural support (PBS) and bringing in technology to people to help improve their quality of life. The locality manager had shared success stories about the technology used with a local authority carer's forum and a local authority celebration day. Also with her knowledge gained with PBS she had become the lead person for a local PBS group. The locality manager told us they had met with professionals over eight meetings. This was to discuss PBS helping people move out of assessment units. This meant the service was being an excellent role model for other services. It worked in partnership with others to build experiences for people based on good practice. The registered managers and staff were striving for excellence through consultation, research and reflective practice.

The provider conducted a number of initiatives to embed the values of the organisation across the staff team. These included themed months, training events and workshops that were cascaded through team meetings. The provider also operated staff recognition awards where staff were nominated to receive a small financial bonus and featured in the provider's newsletter if they had worked in a way that demonstrated the values of the organisation. One staff member told us, "[Provider] does a massive event where everyone comes. They lay down the vision for the company. Lots of events with staff and [people who used the service]." The provider's values and corporate commitments to dignity and care were on display throughout the schemes we visited. The provider had a number of mechanisms for staff and people who

received services to be involved in developing the strategy of the organisation and ways for staff to communicate directly with senior managers of the organisation. These included direct email access to senior managers and drop in sessions for staff. There were steering groups for people who used services which influenced the strategy and development of the organisation. There were systems in place, with cash rewards, for staff to contribute to the strategic direction of the organisation.

The service also held regular staff meetings in each scheme where staff could receive up to date information and share feedback and ideas. Topics included in staff meetings were support plans, medication assessments, themed months, black history month, activities, GP referrals, positive behavioural support, food menu, finances, infection control, baking competition for people and updates on people who used the service. One staff member told us, "Meetings help us catch up and work as a team and a key worker. It does really help us."

The provider had a number of quality monitoring systems in place. These were used to continually review and improve the service. The provider had a system whereby scheme managers completed monthly self-audits of their services which were submitted to the registered managers to review. There was also an annual system for registered managers to peer audit each other's services. The complex needs manager told us they were about to change the annual audit to twice a year. The last annual audit completed was June 2017. These audits considered care plan documentation, risk assessments, medicines, health and safety, the physical environment, observations of care, incidents, accidents and safeguarding, complaints, staffing records, training and activities. These audits generated an action plan in the services. Records showed that where these audits had identified concerns about schemes clear action plans had been put in place. For example, the annual audit has identified a training matrix was needed for each of the schemes. This was actioned and completed July 2017.

The complex needs manager collated the information collected from audits and information from these were presented at board level. This meant the provider had senior level oversight of the services. The complex needs manager was the chair of the local registered manager's network which was used to share good practice and innovations among registered managers locally.