Lifeways Community Care Limited

Lifeways Community Care (Taunton)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection activity at Lifeways Community Care was announced and took place on 5 and 6 November 2018. This is the first inspection of this service since it changed locations and re-registered in 2017.

We gave the provider 48 hours' notice because we needed to be sure the registered manager would be available for the inspection. It also allowed us to arrange to speak with people receiving the service.
The service is registered for the provision of personal care in people's own homes. This includes support with personal care, such as assistance with bathing, dressing, eating and medicines. We call this type of service a 'supported living' service. At the time of this inspection the service supported 55 people living in seven different premises, including single occupancy and shared occupancy properties, 37 out of 55 people received a regulated activity.

People's accommodation was provided by separate landlords, usually on a rental or lease arrangement. The service was only responsible for the provision of personal care and not for the provision of the seven premises. People who used the service had a wide range of cognitive impairment and/or other support needs, ranging from mild to severe learning disabilities or autistic spectrum disorders. Some of the people had very complex support needs and required support from the service 24 hours a day. Other people were more independent and received support for just a few hours a day to help with their daily routines.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The provider had appointed a new manager, they had been in post for four months and clearly had a commitment to improvement. Although the new manager had submitted their application to become the registered manager of Lifeways Community Care, this had not been finalised. Therefore, in this report when we speak about the registered manager, we refer to them as being, 'the new manager'. The new manager was supported by four service managers who oversaw the staff based in people's houses or flats. For this report when we refer to the service manager we mean the direct line manger to that staff team, not the new manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe with staff supporting them from Lifeways. Staff understood how to recognise and report signs of abuse and there were safeguarding policies and procedures available for staff to access. Staff received safeguarding training and the new manager understood their responsibilities to raise

concerns both internally and externally.

Staff carried out risk assessments that included any environmental risks in people's homes and any risks in relation to the care and support needs of the person. There was a lone working policy and on call procedure which staff were aware of.

The provider had sufficient staff to keep people safe and their recruitment processes minimised the risk of unsuitable staff being employed. The provider obtained references and completed a Disclosure and Barring Service (DBS) check. A DBS check ensures the provider can identify people barred from working with certain groups such as vulnerable adults.

Staff followed a comprehensive medicines policy. Staff received medicines training on induction and were assessed annually to ensure they were competent and safe to manage people's medicines. Medicines incidents were reported. Staff took further training if needed and incidents were used to improve systems safety. Staff followed good infection control practices that protected people and accident and incident reporting was robust.

The provider had systems in place to assess people's needs and choices. Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice, for example on the grounds of their gender, race, sexuality, disability, or age.

Staff had the right skills, knowledge and experience to deliver effective care and support. Staff completed an induction when they started employment at Lifeways. There were records of individual staff appraisals and regular supervision.

Staff understood the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the service adhered to the code of practice. People we spoke with confirmed staff asked for their agreement before they provided any care or support. Care records showed that people gave their consent to the care and support provided.

People received care and support which was personalised to them. Care plans contained comprehensive information about people's wishes or preferred routines. Staff treated people with kindness and respected people's privacy they made sure care was provided in a dignified way and they encouraged people to be as independent as possible.

The provider had a clear vision to deliver high-quality care and support that promoted a positive culture. There were effective quality assurance systems in place to monitor care and plan ongoing improvements. The registered manager was aware of their legal responsibilities and worked in partnership with other organisations and there was a system in place to manage and investigate any complaints.

Further information is in the detailed findings below

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.

Peoples medicines were managed safely

There were sufficient numbers of staff to meet people's needs.

People were supported by staff who had been safely recruited.

Risk assessments were in place for both people and the environment.

Infection control procedures were in place.

The registered manger understood their responsibilities to raise concerns and record safety incidents.

Is the service effective?

Good

The service was effective.

Staff had the right skills, knowledge and experience to deliver effective care and support.

There were records of staff appraisals and staff received regular supervision with a manager.

The provider supported people to eat and drink enough to maintain a balanced diet.

Staff worked successfully with healthcare services to ensure people's health care needs were met.

The provider sought peoples consent to care and support.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness respect and compassion.

People felt involved in decisions about their care and told us they

could express their views about how their care was delivered.

Staff respected people's privacy and made sure care was provided in a dignified and respectful way.

Staff were aware of confidentiality and records were stored securely.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed before they moved in to the home.

The support plans were set out clearly and easy to read.

The provider complied with the Accessible Information Standard by identifying and recording the communication needs of people.

There was a system in place to manage and investigate any complaints.

There were ways for people and their representatives to express their views about the quality of the service provided.

Is the service well-led?

Good

The service was well led.

The provider had a clear vision to deliver care and support that promoted a positive culture.

The registered manager had a clear understanding of the key values and focus of the service.

There were effective quality assurance arrangements in place to raise standards and drive improvements.

The provider had followed all relevant legal requirements, including registration and safety obligations and the submission of notifications

Lifeways Community Care (Taunton)

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.

Inspection site activity started on 5 November 2018 and ended on 6 November 2018. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the new manager would be available for the inspection. It also allowed us to arrange for people receiving the service to be visited in their own homes.

One adult social care inspector, one medicines inspector and one expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and other information we held about the service.

During our inspection, we spoke with the new manager, the office manager, two service managers and nine support workers. We spoke with 15 people who received personal care and spoke with three members of their family who were closely involved in their care and support. We also visited six people in their own homes. After the inspection, we contacted five health and social care professionals to seek their views on the service. Two responded.

We looked at records relevant to the management of the service. These included eight care plans. We reviewed risk management plans, health and safety records, complaint and incident reports, six staff

recruitment files, training records, medicine management records, and performance monitoring reports.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments from people included, "Staff look after me". "It's alright here". And, one person said, "I was bullied before". They added, "They (staff) helped me report it." Another person said, "Yes they look after me".

Staff understood how to recognise and report signs of abuse or mistreatment. Safeguarding and whistleblowing policies and procedures were available for staff to access and staff had received training on how to recognise the various forms of abuse, which was regularly updated.
Staff described what they would do if they thought someone was being abused. One staff member said, "Abuse is reported to the line manager, they investigate, and decide the best way forward". They added, "The manager will raise a safeguarding to the local authority if needed".

The new manager understood their responsibilities to raise concerns and record safety incidents and report these internally and externally as necessary. Staff told us if they had concerns, management would listen and take suitable action. If the new manager had concerns about people's welfare, they liaised with external professionals. We reviewed safeguarding referrals, including actions taken, the provider had sent to the local authority.

Staff carried out risk assessments to identify any risks to the person using the service and to the staff supporting them. This included any environmental risks in people's homes and any risks in relation to the care and support needs of the person. One staff member told us, "We encourage risk taking". Adding, "We went to a carnival and one person wanted to go off on their own". They also said, "We asked (person's name) to tell us where they were going and checked they had their phone". Another staff member told us, "People have a number logged on their phone, it's an, "In case of emergency" number". They added, "It's in people's phones as ICE, in case of emergency, they can call this number and get through to someone for help".

Staff worked in line with risk assessments. For example, one person smoked and had a risk assessment in place that said they must have their hair out of the way when smoking, and they should use wind resistant lighters and metal ashtrays. This meant the person could exercise their choice to smoke and remain safe whilst doing so.

There were systems in place to safeguard and protect staff. There was a lone working policy and on call procedure which staff were aware of. Staff had access to a mobile phone for going out in the community. One staff member said, "If there was a risk identified we follow the risk assessment in place". Another staff member told us, "We rarely work on our own, except maybe at night, as most people lived in communal houses". Adding, "Those who didn't had two staff members supporting them".

Staff had assessed some people who used the service as having behaviours which might challenge themselves or others. There was guidance in place which gave staff clear information about the triggers they should look for. The guidance also gave staff strategies to follow to reduce the risk of such behaviours occurring or escalating. Staff told us they understood how to follow this guidance. For example, one staff

member told us, "(Persons name) bangs their head when they get anxious". Adding, "I have got to know them and know they love going out in the car, we take them out as much as possible which helps reduce their anxiety, that means they don't bang their head as much so keeps them safe". Another staff member said, "We get to know people, that's how we manage their behaviours, we know the signs and we distract people before it gets worse".

The provider had sufficient staff to keep people safe. The number of people using the service and their needs determined staffing levels. The provider currently employed 135 staff members and had 15 vacancies. The provider contacted sessional staff in the first instance and then used agency staff that were familiar with the service and staff told us they worked additional hours. One staff member said, "We don't mind working extra, we know its appreciated". Another staff member said, "If we cover it means people don't have their care and support changed". The provider produced a rolling rota in advance which the staff appreciated as it meant they knew their working hours and people had consistency and knew who would be on shift each day.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. The provider obtained references and completed a Disclosure and Barring Service (DBS) check. A DBS check ensures the provider can identify people barred from working with certain groups such as vulnerable adults.

Staff followed a comprehensive medicines policy. Staff received medicines training on induction and were assessed annually to ensure they were competent and safe to manage people's medicines. Medicines incidents were reported. Staff took further training if needed and incidents were used to improve systems safety.

Staff worked with people to identify their medicines support needs. These were documented in their care plans. People received their medicines, including over the counter medicines, appropriately. Guidance was available to help staff decide when a medicine might be needed or where creams should be applied. People receiving care were involved in writing this guidance and informing new staff where appropriate. People continued to receive their medicines safely when they left the service, for example for the weekend, because staff worked closely with parents and carers to transfer information about medicines.

We did see that one person was prescribed a medicine to be taken when required, but there was none in stock. Staff described how the previous supply had gone out of date because it was no longer needed. Communication from the prescriber showed that this medicine had been stopped earlier in the year, but restarted later. We discussed this with staff and recommended they liaise with the prescriber to determine if this medicine is still required and if it is they should arrange for a small supply to be held in stock.

Where staff were responsible, medicines were ordered, stored, given and disposed of safely. Staff signed medicine administration records (MARs) when people had medicines administered or recorded a code if a medicine was not given. MARs were accurate, although lots of changes needed to be made to the printed MAR received from the pharmacy. We discussed this with staff and recommended they contact the pharmacy supplier to update MARs to reduce the risk of medicine errors.

Staff followed good infection control practices that protected people. Staff understood their role and responsibilities for maintaining standards of cleanliness and hygiene when delivering care and handling food. Staff told us they had access to policies and procedures on infection control and records showed staff received infection control and food hygiene training. Staff said, "We always wear gloves and aprons when working with people". One staff member told us, "We help (person's name) use a probe to register the temp of cooked meats when cooking so it is safe for them to eat". Another staff member said, "When people go on

social leave we tend to do a deep clean of their rooms as well".

Accident and incident reporting was robust. Staff knew the reporting process. Records showed that staff had taken proper action where necessary and made changes to reduce the risk of a re-occurrence of an incident. Where incidents had occurred, the new manager had investigated thoroughly and used this to make improvements to the service. Staff said they received the outcome of an incident through staff meetings and handovers, which meant staff, received learning from the incidents that occurred.

Good

Is the service effective?

Our findings

The provider had systems in place to assess people's needs and choices. Copies of pre- admission assessments on people's files were comprehensive. These assessments helped staff to develop a care plan for the person so care was delivered in line with current legislation, standards, and guidance. One staff member told us," We think about the dynamics as well". They added, "We had one person living at one house who didn't get on with the other people so we arranged for them to move to a more appropriate house where they are settled". One person told us, "Staff ask me about stuff all the time".

Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability, or age. Staff told us, "Everyone is an individual they all like different things so we help them do what they like". Another staff member said, "People we support all have different needs, from lots of support to very little support they are all different". One person told us, "They (staff) are very good, I just say no, and they say, that's okay". Another person said, "Staff are ok they do what I want them to".

Staff had the right skills, knowledge and experience to deliver effective care and support. Staff completed an induction when they started employment this included shadowing more experienced members of staff. Shadowing continued until the person and their service manager felt confident that they were comfortable and competent to carry out their role. All staff who were new to the service completed the Care Certificate. The Care Certificate is an identified set of national standards that health and social care workers should follow when they are new to work in the care sector. People we spoke with about staff skills said, "I think they are trained". "They help me ok". Another person said, "They help me calm down when I get anxious they are good at that".

Records showed staff received training which enabled them to carry out their roles effectively. There was a system in place to remind staff when their training was due to refreshed. The office manager told us, "I request training for staff they get an email to complete the training". They added, "I get a notification on our new system telling me when staff are out of date and I can run reports to see who's up to date". They also told us, "We have a trainer linked to the Southwest, they do all the induction training".

Aside from the subjects which the provider considered to be mandatory, such as infection control and safeguarding, staff told us they received training which was relevant to the individual needs of the people they supported. For example, staff told us they had training in emergency medicines for people who had epilepsy, and dysphasia so they could support people who had difficulty with verbal communication.

Staff told us they felt supported in their roles. There were records of individual appraisals and regular supervision with a service manager. Supervision is a process where members of staff meet with a supervisor to discuss their performance, any goals for the future, and training and development needs. One staff member said, "Yes we have supervision, the support is good". Another staff member said, "(Service managers name) is brilliant, they just support us so well".

Some people needed support at mealtimes to access food and drink of their choice. Staff had received training in food safety and were aware of safe food handling practices. A staff member told us, "We plan a week's menu with people then help people to shop for the ingredients". One staff member said, "I sat with (person's name) and did the meal planner with them". Adding, "(Persons name) doesn't stick to the planner, they go to fridge and choose what they fancy on the day". Another staff member said, "(Persons name) just goes to the cupboard and says, "I want that and that". One person we spoke with told us, "I make the menu up, fish and chips on Friday, cottage pie, roast pork and roast dinner on a Sunday". Another person said, "Quite nice, I have my food here, I go shopping every Friday". A relative confirmed, "Staff cook meals, they can choose what they eat".

Staff had supported people to attend medical appointments in accordance with their individual needs. These included GP and other healthcare specialists such as psychologists, speech and language therapists and occupational therapists. Staff told us, "Recently (person's name) had input from the behaviour team and psychologist who had completed a positive behaviour referral and arranged for staff to receive training from the local authority". One person told us, "I see a doctor, but only if I am seriously ill, the staff take me." Another person said, "Yes, we go down to the GP, Dentist and eyes, I go with the staff." A third person told us, "I go and see the doctor, I went to see the doctor last week, I went to the dentist last year and the next one is not until March." A relative told us, "Staff take (person's name) to see the Doctor if they need to, they are very good at picking up if (person's name) feels unwell".

Each person had a health action plan. This document contained important information to help support people if they were admitted to hospital. Care records demonstrated staff shared information effectively with professionals and involved them appropriately. One professional told us "They act on actions from reviews promptly". Another professional said, "They work with the family to come up with plan so that (person's name) can live as an individual".

The provider met people's individual needs through adaptation, design, and decoration of premises. People were involved in the design of their homes and could personalise them to reflect their likes and preferences. One person told us, "I choose my things". This person showed us the pictures they had drawn and had on display. Another person told us, "Yes, I have pictures on the bedroom wall and in my chill out room I have my teddy bears and my own paper". We observed homes to be very personalised and full of things people wanted, such as personal pictures on the walls photos and ornaments in their lounges.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for people living in supported living situations or in their own homes can only be authorised through the Court of Protection. These applications are completed and submitted to the court by the local authority. At the time of the inspection 27 people receiving personal care from the service currently required this level of protection because they all received continuous supervision. The provider had submitted the requests to the local authority but had not had them authorised. We discussed this with the manager who told us they had chased them but were aware there was a back log of applications being dealt with.

Staff understood the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the service adhered to the code of practice. The care records we reviewed contained assessments of the person's capacity to make decisions. Some people who used the service lacked capacity to manage their finances and we saw that appointees had been set up for these people to manage their money in their best interest. Staff knew what this meant for the people they supported. Staff had attended best interest meetings where professionals and family members made decisions on behalf of people who lacked capacity.

Staff told us they asked people for their consent before delivering care or support and they respected people's choice to refuse care. People we spoke with confirmed staff asked for their agreement before they provided any care or support. Care records showed that people gave their consent to the care and support provided.

Good

Is the service caring?

Our findings

Staff treated people with kindness respect and compassion. This was reflected in the feedback from people who used the service. Comments from people included, "Staff are very nice, all very nice", "There is always someone to help me", "Yes, they are very kind to me". And, "Yes, they sit and chat and listen to me". We also spoke with a relative who said, "Yes you can just tell by how (name) responds to them". Another relative said, "You can just see the rapport with (name)". Adding, "They are comfortable and happy".

Staff spoke about people with affection and it was clear they had built trusting relationships. When they discussed people with us they were respectful and knowledgeable. Comments from staff included, "I have a positive relationship and have gained trust, seeing (person's name) happy, that's everything". We also observed staff on home visits, staff interacted with kindness and respect addressing people appropriately. We saw people and staff laughing together and discussing things in a friendly manner.

Staff encouraged people to be independent and make choices about day-to-day aspects of their life at the home. All the people we spoke with could not say if they had a care plan or if they had been involved in writing one. However, people did say they were able to make their own decisions, for example, one person said," If I want to go out at night someone goes out with me". Adding "I go shopping on my own and volunteer at a furniture shop". Another person told us, "I am getting a new car soon". Adding, "I keep really busy". A third person said, "I belong to a group, we go out into town, I enjoy that". Relatives told us, "We had a review about eight weeks ago we do try to have a yearly review". Another person said, "Social Services don't attend anymore". A third person said, "I am in contact with the manager, and if I have any concerns I can contact directly." Adding, "I have always been involved in reviews". Another person we spoke with told us, "Last year they wanted to move and I was very involved in that". Adding, "Big things I'm involved in, they would inform me if it was something serious."

People confirmed they could have visitors whenever it suited them; for example, one person said, "I get visitors sometimes. I don't get many." Another person told us, I have visitors. We usually go out". A third person told us, "Yes my family come and see me and I go to see them".

Staff respected people's privacy and made sure care was provided in a dignified and respectful way. People could choose the gender of the staff member who assisted them with personal care, and choices were respected. One person told us, "They do knock on the door." Another person said, "They knock on the door and then come in." A relative told us, "Yes (person's name) showers them self and they knock on the door and say, "Are you done?". Another relative said, "They won't barge in, but they check (person's name) is okay." Another relative said, "I would say yes, (person's name) would be the first to grumble if they were getting in their way".

Staff were aware of confidentiality and did not speak about people in front of other people. When they discussed people with us they were respectful and knowledgeable. People we spoke with confirmed that staff did not speak about people in front of them. One person said, "I don't think they talk about me to other people". Another person told us, "They talk about what I need to do when they come here". Relatives we

spoke with told us, "Staff seem very nice, I don't think they would gossip about other people, I've not heard anything".

Good

Is the service responsive?

Our findings

People received care and support which was personalised to them. Care plans contained comprehensive information about people's wishes or preferred routines, staff knew people well and respected their wishes which was important because some people receiving support had limited or no verbal communication. One staff member told us, "Knowing people as we do helps us support their chosen lifestyles, cultures, and religions". Another staff member told us, "We know people really well". Adding, "It's our job to get to know people and know what they like". One person told us, "Staff have known me for a long time and they help me stay calm they know how to distract me".

There was some confusion as to which plans were the most relevant. This was because the provider had copies held in people's homes, electronically and in folders in the office base. This meant that any new staff coming in may not access the most up to date information. We spoke to the new manager about this who told us this was the providers policy but they could see how it was not necessary to keep so many copies. They explained that the files in people's home were the most up to date and would be in line with the electronic records and they would consider archiving the third copy.

People planned their weekly activities with a member of staff and could discuss their support needs on day to day basis or more formally during their annual reviews where the new manager, family members and a social worker would be present. One person told us, "The only thing I like is going out." They added, "I'm looking forward to Christmas, at Christmas I go down to my mum's and I visited my mum last weekend." Another person said, "I go to pubs, but not clubs, it depends on who's (meaning staff) is here." Another person said, "Monday, is grocery shop, Friday we go to charity shops and when it's my birthday we go out for a special pub meal." A relative told us, "(Persons name) goes to the gym and swimming twice a week". Another relative told us, Staff sense whether they are enjoying things, or not". Adding, "(Persons name) loves walking, they are a member of the National Trust, and staff took them to Filton air museum as they love planes". Another relative told us, "(Persons name) sister is getting married in two weeks, two staff are going to support them to go."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Some people had no verbal communication. Each person had a communication profile in their care and support plans which meant staff knew how people communicated and what certain sounds and gestures meant for that person. Staff told us they used a variety of methods to communicate with people, which included verbal communication, sign language and pictures. During the inspection we saw staff signing to with one person which enabled them to understand the questions the inspection team asked.

There was a system in place to manage and investigate any complaints. The new manager sought people's feedback and addressed any issues raised. The provider underpinned this with a policy and procedure, which staff knew. Records showed formal complaints were responded to promptly and the complainant was told of the outcome of investigations. Where concerns or complaints highlighted shortfalls in the

service action was taken to make future improvements. People we spoke with told us they were confident the provider would deal with any complaint to their satisfaction. One person told us, "I would just tell (staff members name)". Another person said, "I can tell staff if I have a problem they will help me". A relative told us, "Yes, I would go to the manager first if I had a problem but I've never made a formal complaint". Another relative told us, "I have got the complaints procedure somewhere". A third relative told us, "I just emailed the manager about something (person's name) has told me". Adding, "The manager spoke to persons name) and emailed me back".

At the time of the inspection, no one was receiving end of life care. Staff were aware to liaise with the person's GP and the district nurse team in the event someone did need end of life care. Staff told us and records confirmed, people could complete a, "When I die" document or a disclaimer to say they don't want to discuss it. Staff also said there is training available if required.

Good

Is the service well-led?

Our findings

The provider had a clear vision to deliver high-quality care and support that promoted a positive culture. Care and support was person-centred, open, inclusive and empowering and achieved good outcomes for people. The new manager had only been in post for four months but had already made clear they expected people to receive a high standard of care in a safe environment.

Staff told us the new manager was a good leader and they hoped they would stay as their registered manager. 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 feedback we received throughout the inspection was positive. People and their relatives told us they were happy with the care and support they received. People told us they knew the staff well and were getting to know the new manager. We observed good communication between people and the staff teams. It was clear people liked being around staff we observed relaxed interactions between people and all staff.

Staff told us their line managers were supportive, which they appreciated. One staff member said, "(Managers name) is just brilliant". adding, "(Managers name) gives me enough rope to get on with things, I'm trusted". Another staff member said, "We all work as a team". It was evident the new manager and their teams were passionate and dedicated to providing an excellent service to people. The staff team were encouraged to continuously improve the lifestyle and wellbeing of the people they cared for. This meant they were totally committed to providing the best service they could deliver, resulting in the best possible outcomes for people.

There was a management structure in the service, which provided clear lines of responsibility and accountability. The new manger made any decisions about the development of the service collectively with the staff team. Four service managers, an office manager, and seven scheme managers supported the new manager. There was also an administrator based in the office who supported the managers with the day to day running of the service.

There was a culture of support and cohesiveness amongst managers and staff. There were manager's meetings to discuss the business; and regular staff meetings that ensured there was good communication across the whole team. We reviewed the team leaders "Driving up quality meeting "dated March 2018. Areas discussed included audits, action plans, new policies, on call appraisals and supervision. The latest managers meeting took place in October 2018 and focused on recent audit results and health and safety.

The provider valued staff and appreciated their contributions. Staff told us, "We don't mind doing extras, we know its appreciated". Another staff member said, "They support us so we support them it works both ways". There was a commitment to ongoing improvements. The new manager had a quality action plan in place to ensure improvement were being made when shortfalls had been identified. For example, audits of

staff wellbeing had highlighted that Staff working long hours with people with complex needs should be able to safely have a comfort break.

Staff, People and their families could express a view about the service provided through an independent annual survey. Staff and people, we spoke with also said they were encouraged to discuss their needs every day because things change so regularly. One person told us, "Yes we send back a form answering some questions about the service, every year I think". Another person said, "You can do it anonymously". A relative told us, "We do get a questionnaire from time to time, once every 6-12 months." Another relative said, "We are just happy (person's name) is in a place that is coping with them and they are happy".

There were effective quality assurance systems in place to monitor care and plan ongoing improvements. Service managers completed a workbook three monthly which included health and safety, infection control and medicines management. The workbooks were reviewed by the new manager and where staff had identified shortfalls in practice the provider took action to improve the service. Service managers also checked people's financial transaction records weekly which were then sent to the office to be double checked. Staff told us, some were also sent to family members or the local authorities finance team.

People lived in homes which were well maintained by their landlords. There were regular checks on the buildings including the fire detection systems and water temperatures. Staff reported to the individual persons landlord if maintenance was required to make sure people lived in a pleasant environment.

The provider was transparent, collaborative, and open with all relevant external stakeholders and agencies. Staff worked in partnership with key organisations to support care provision, service development, and joined-up care. This helped to make sure people received care and support in accordance with best practice guidance. One professional we spoke with said, "The staff have always been supportive and worked with us". Another professional told us, "They are one of the better ones". Adding, "They are proactive and always take on board our suggestions".

The registered manager was aware of their legal responsibilities and worked in partnership with other organisations such as commissioners and the local authority to share information appropriately. The registered manager has notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities.