The Wilf Ward Family Trust

The Wilf Ward Family Trust Domiciliary Care York

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

We inspected this service on the 8 and 10 February 2016. The inspection was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be in the location offices when we visited.

The Wilf Ward Family Trust Domiciliary Care York is registered to provide personal care to people living in their own homes and specialises in supporting people who may be living with a learning disability, dementia or mental health conditions. At the time of our inspection there were 37 people using the service living across 15 supported living houses, flats and bungalows within York. People living in these houses were tenants of either The Wilf Ward Family Trust Domiciliary Care York, who owned two of the properties, or an independent housing provider who was responsible for the maintenance and upkeep of the buildings.

This was the first inspection of this service at this location.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). 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.

During the inspection we found that the service was safe. There were systems in place to support staff to appropriately identify and responded to signs of abuse to keep people safe. Risks were identified and steps taken to minimise risks to keep people safe.

There was on-going recruitment and monitoring of staffing levels to ensure that people's needs continued to be met. There were safe recruitment processes in place so that only people considered suitable were employed.

Medication was managed and administered safely. Where concerns were identified action was taken to address this and a new medication process introduced.

Staff received training and on-going support in their role. People using the service were supported to make decisions in line with relevant legislation and guidance.

People were supported to eat and drink enough and to access healthcare services where necessary.

We received positive feedback about the caring nature of staff. Staff were observed to be warm, responsive and attentive to people's needs. People had developed meaningful caring relationships with the staff who supported them.

Staff supported people to have choice and control over the care and support they received and people were treated with dignity and respect.

Care plans contained person centred information and staff were knowledgeable about people's needs as well as their preferences, hobbies and interests.

There was a system in place to ensure people could raise concerns or make a complaint if necessary. Complaints were appropriately investigated and responded to.

The service was well-led. Feedback was generally positive about the management of the service and there were systems in place to monitor the quality of the care and support provided and to drive improvements.

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 understood how to appropriately respond to safeguarding concerns to keep people using the service safe.

People's needs were assessed, risks identified and risk assessments put in place to prevent avoidable harm. Staff were knowledgeable about people's needs and the care and support required to keep them safe.

There were sufficient staff to meet people's needs. Agency staff were used where necessary to maintain safe staffing levels.

Staff were trained to administer medications safely.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to effectively carry out their roles. Staff we spoke with were knowledgeable and experienced.

People were supported to make decisions.

People were supported to eat and drink enough and access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

People using the service had developed meaningful caring relationships with the staff supporting them.

Staff effectively communicated with people using the service to support them to make decisions and have choice and control over their daily routines.

People's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and person centred care plans developed to guide staff on how to meet identified needs.

There was a system in place to manage and respond to compliments and complaints.

Is the service well-led?

Good

The service was well-led.

Feedback we received was generally positive about the management of the service.

There were systems in place to monitor the quality of care and support provided.

Where concerns or issues were identified, action was taken to address this and to drive improvements.

The Wilf Ward Family Trust Domiciliary Care York

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 registered 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.

We inspected this service on 8 and 10 February 2016. The inspection was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be in the location offices and supporting living schemes when we visited.

On the first day, the inspection team was made up of two Adult Social Care Inspectors. On the second day, the inspection team was made up of one Adult Social Care Inspector and an Expert by Experience (ExE). An ExE is someone who has personal experience of using or caring for someone who uses this type of service. The ExE supported our visits by speaking with people using the service and observing interactions. The ExE also telephoned people using the service and their carers or relatives to ask for their feedback.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought relevant information from City of York Council's safeguarding and commissioning teams.

As part of this inspection we visited the location offices and three supported living schemes. During our visits we spoke with six people using the service and spent time observing interactions. We spoke with the registered manager, the deputy regional manager, two managers of supported living services and seven care workers. We also looked at four people's care records, three care worker recruitment and training files

and a selection of records used to monitor the quality of the service. Following our visit we spoke with 12 relatives and two people using the service by telephone and one health and social care professional.

Good

Is the service safe?

Our findings

People using the service told us "It's lovely here, they look after me and they keep me safe." Other people we spoke with used non-verbal means of communication to show us that they were happy and felt safe with the care and support provided by The Wilf Ward Family Trust Domiciliary Care York. We observed that people using the service were relaxed and at ease in their surroundings and we saw multiple examples where people reacted positively towards staff and were keen to approach and interact with them. This showed us that people using the service felt safe.

The registered provider had a policy and procedure in place to guide staff on how to safeguard vulnerable adults from abuse; although we noted that this needed to be updated to reflect changes introduced by the Care Act 2014. Records showed that staff had training on how to recognise and respond to signs of abuse and staff we spoke with showed a good understanding of their roles and responsibilities with regards to safeguarding vulnerable adults. One member of staff told us that if they had safeguarding concerns "I would speak to the manager or, if they were implicated, I would go above them and report it to the next person higher up."

The registered manager maintained a safeguarding log to record all safeguarding concerns. This showed us that there had been eight safeguarding concerns identified and referred to the local authority safeguarding team. The Care Quality Commission had been appropriately notified of these safeguarding concerns and, where additional information had been requested, this was provided. These records showed us that safeguarding concerns were acted upon in consultation with the local authority.

We reviewed four people's care plans and saw that their needs were assessed, risks identified and risk assessments put in place to guide staff on the care and support needed to prevent avoidable harm. Risk assessments identified risks to the individual and staff and documented, for example, what equipment was in place to minimise the risks and how care and support should be provided by staff to further reduce risks to keep people safe. We saw risks assessments covering mealtimes, the administration of medication, moving and handling and epilepsy. Care plans and risks assessment incorporated information and advice and guidance from relevant healthcare professionals where appropriate.

We observed that staff encouraged and supported people to maintain their independence, but people's safety was maintained as staff were attentive and responsive to their needs and provided supervision and support where necessary. We asked staff how they kept people using the service safe, comments included "By reading the care files, we know people well, we know how to deal with situations and stay calm" and "People are very safe, we pay attention to their needs so people are comfortable." Staff we spoke with were knowledgeable about people's needs and the risks associated with providing their care and support. For example, one member of staff explained how they supported a person using the service if they became distressed or anxious. They explained what could cause this behaviour, how best to respond and provided details about their hobbies and interests and explained how they used this as part of distraction techniques to avoid confrontation.

Accidents, incidents and near misses were recorded and a report sent to the registered manager to review and sign off when they were satisfied that appropriate action had been taken. We reviewed a selection of accident and incident records and saw that details of what had happened and the immediate action taken were recorded. Reports were then signed off, following an investigation, by the registered manager. For example, one person using the service had a seizure whilst carrying a cup of tea and had sustained a minor injury. The subsequent investigation concluded that the person's risk assessment needed to be updated to include staff supporting them when carrying drinks and further advice and guidance sought from the Epilepsy Nurse regarding the increased frequency of seizures. This showed us that systems were in place to proactively respond to accidents, incidents and near misses to reduce the risk of future harm. The registered manager explained that all accident and incidents reports were sent to the registered provider who collated, monitored and conducted analysis to identify any patterns or trends.

We reviewed records relating to three staff and saw that references were obtained and Disclosure and Barring Service (DBS) checks completed before they started work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. This showed us that there were systems in place to ensure that only people considered suitable to work with vulnerable adults had been employed.

Staffing levels varied across the supporting living services depending on the specific needs of the people living there. The registered manager told us that people's needs were assessed by the local authority who determined the level of support required and, from this, the number of support hours funded each week. This meant that each supported living service had a certain number of support hours available to meet the needs of the people living there. The majority of these hours were communal hours to support all people living in that service, however, some were dedicated 'one to one hours' to support an individual with activities or going out. Where people were funded one to one hours, care plans contained a record of when these were used. This could be used to ensure that people received an appropriate level of support to meet their needs.

We reviewed the rotas for the three supported living schemes we visited and saw that shifts were covered by staff or agency workers where necessary. Staff we spoke with told us "Staff pick up extra shifts and help each other out, we do overtime and even take people out in our own time if needed." However, another member of staff told us "Staffing levels have been a bit precarious, for instance agency staff let us down today…we've not been able to get everyone out, we have to take people out in turns."

At the time of our inspection the registered manager told us that they had eight staff vacancies across the supported living services. The registered manager told us that there was on-going recruitment to these vacancies. We saw that 13 staff had started since November 2015 and a further 15 staff had been appointed, but had not yet commenced in post. This showed us that the registered provider was taking proactive steps to recruit staff to maintain staffing levels.

Service managers we spoke with told us they were required to submit a weekly report which included details about the number of available hours, the number of delivered hours and information about the number of agency staff used. We reviewed these records and saw that they were an effective tool to enable the registered manager to monitor staffing level across the supported living services. Where discrepancies between the available and actual care hours had occurred an explanation was provided to account for this.

The registered provider had a medication policy and procedure in place to guide staff in the safe administration of medication. Staff we spoke with told us they had training on medication management and

that competency checks were carried out before they were allowed to independently administer medication; one worker commented "I had to be observed giving medication and was signed off as competent." We saw evidence of completed medication competency checks in staff files.

Care plans contained medication support plans and risk assessments documenting the level of support people required to take their prescribed medication. We observed that medications were stored securely in people's rooms or in a treatment room at the supported living services we visited.

We reviewed Medication Administration Records (MARs) used by care workers to document prescribed medication given to people using the service. We saw that MARs were completed correctly and there were no gaps in recordings. MARs recorded a running tally of medication in stock and our random spot checks showed these records to be accurate.

We saw that body maps were not used in one of the supported living services we visited and we spoke with the deputy manager about the importance of using these to guide staff as to which part of the body topical creams needed to be applied.

The registered manager showed us a log they kept to monitor and address concerns around medication management. Where medication errors had occurred, we saw records that these had been investigated and action taken to address concerns. We saw that discussions around medication errors were recorded in people's supervision sessions and, where a number of medication errors had occurred in one supported living house, a new specific medication policy had been introduced to successfully address these concerns.

Good

Is the service effective?

Our findings

People we spoke with gave positive feedback about the skills, knowledge and experience of staff and we observed a number of positive interactions in which staff demonstrated a range of skills and expertise in meeting people's needs.

We reviewed the registered provider's induction and training programme. New care workers had to complete induction training and shadow more experienced workers to equip them with the skills and knowledge needed to carry out their roles effectively. One care worker described how they had completed three weeks of induction training and shadowing before working independently and commented "I observed other colleagues to get hands on experience….the support was brilliant. I could always ask questions." We reviewed the induction schedule and saw that induction training covered topics including health and safety, communication, moving and handling, safeguarding and medication management.

In addition to induction training staff were required to complete refresher training to update their skills and knowledge. The registered manager showed us a copy of a training matrix they used to monitor the training needs of all staff and a copy of the training schedule showing courses available to staff in the coming months. This showed us that staff received regular training throughout the year. Staff we spoke with were generally positive about the training provided although one person commented "I sometimes feel the training is not there, I expected more, but I always get the support I need." They explained that where they sought additional advice and guidance that this was always provided.

The registered provider had a supervision and appraisal policy. Staff we spoke with told us they had supervisions and annual appraisals to support them to develop in their role. One member of staff told us "I have SDSs [staff development sessions] – I get asked about my development/learning needs and service user knowledge." We saw records of supervisions completed evidencing these discussions.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the registered providers were working within the principles of the MCA.

We saw that staff completed MCA training and staff we spoke with showed a good understanding of the importance of gaining consent and supporting people to make their own decisions. We saw that care plans recorded information about people's capacity to make decisions; for example one care plan recorded that the person could make simple choices and gave examples, but advised that a best interest meeting could be needed, involving family and professionals, for more complex decisions. Best interest meetings are used to

make a particular decision on a person's behalf where they have been assessed as lacking mental capacity.

Care plans contained details about people's communication needs and recorded information about how best to engage and communicate with people to support them to make decisions. One person using the service had been supported to develop a communication book with input from their Speech and Language Therapist (SALT). This included a range of pictures to be used to support them to communicate.

The registered manager explained that people who lacked capacity and might be deprived of their liberty had been identified and details sent to the supervisory body, in this case the local authority, for their advice, guidance and further assessment.

The registered manager understood the role of advocacy services and how to seek support where necessary. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

During our inspection we observed that staff supported people to ensure they ate and drank enough. Care plans we reviewed contained information about the level of support people required with eating and drinking, details about specific dietary requirements or nutritional needs and information about foods people liked and disliked.

Staff we spoke with were knowledgeable about the specific dietary requirements of the people they were supporting. Two staff told us about a diabetic person they supported with preparing meals. They explained how the diabetes affected the person, what types of foods the person could and could not eat and alternatives that could be offered. One member of staff explained how they supported the person to go to the supermarket and buy healthy alternatives to promote their choice and independence.

Staff told us "We do have a menu, but if they don't want that choice we change it" and "We do a menu on a weekend and ask people what they want. [Name] communicates non-verbally, but it is in their support plan what they like and their parents tell us what they like." People using the service told us "The food's nice."

We saw that care plans recorded information about what people ate and drank. These records showed, and our observations confirmed, that people were supported to eat a varied and nutritious diet and to drink regularly. We saw that where necessary fluid charts were in place to monitor what people drank to manage the risk of dehydration. We spoke with the manager at one of the services we visited about the importance of adding up people's fluid intake over a 24 hour period to ensure that if the person had not drunk enough this would be identified.

We observed that food was stored appropriately, fridge temperatures were monitored and food dated on opening to ensure that it could be disposed of when past its expiry date.

Care plans contained information about people's medical history, current health needs, prescribed medications and contact details of healthcare professionals involved in supporting them. Where people had specific support needs, health care plans had been put in place. For example, one person had diabetes. Their health care plan contained a detailed description of the potential impact of this and the support to be provided to promote their health and wellbeing. We saw other examples where health care plans incorporated advice and guidance from relevant healthcare professionals to ensure that staff were providing care and support based on up-to-date knowledge and professional guidance.

Staff we spoke with told us "We have a diary so if there are any appointments or visits we see it in there" and

"We take them to medical appointments." Records showed that people were visited by or supported to visit healthcare professionals where necessary and that staff responded effectively to concerns about people's health and wellbeing.

Good

Is the service caring?

Our findings

People using the service told us that they were "Looked after" and "Cared for." Other people we spoke with said "I like the staff" or responded positively though non-verbal communication when we asked them about the staff.

Relatives we spoke with told us that staff were caring, understanding and treated people with dignity and respect. Comments included "I am very happy with Wilf Ward Trust, staff have people's best interests at heart", "I'm more than happy with the care" and "[Name] is more cared for now than they've ever been!"

We observed that people using the service responded warmly to staff showing us that they had developed positive relationships with them. Throughout our inspection we saw that staff displayed a caring attitude in the way they interacted both verbally and nonverbally with people using the service. We observed that staff were friendly, kind and attentive to people's needs. Staff demonstrated through what they said and how they cared for people that they understood people's needs. Staff were consistently able to tell us important information about the people they were supporting including information about their needs, preferences, hobbies and interests.

We asked staff how they go to know people using the service and develop meaningful caring relationships. Comments included "We are with them constantly so we know them well" and "We spend time with them so we know them." We saw that each supported living house, bungalow or flat had a dedicated staff team and this meant that there was a level of consistency in the staff providing support. This supported staff and people using the service to develop positive caring relationships. Although agency staff were used, staff told us "We try and use the same agency staff, it's very important. [Name] gets agitated if they do not know the staff" and "We use regular agency staff, they're like a permanent member of staff." Whilst a member of agency staff told us "I had a very good induction when I came here, they make agency part of the team and do not treat me as an agency worker…I read everything [care plans] and then sat down with staff and they explained everything paying particular attention to people's specific needs."

We asked staff how they supported people to express their wishes and views and be involved in making decisions about their care and support. One member of staff told us "I avoid asking leading questions… because I know their motivations I have an idea of what they may like and then narrow it down to say three options, but it's really down to them. We also use images to help people decide." Another member of staff told us "I know the kind of things they enjoy and I ask them and try to motivate them to decide. I give options and give alternatives; we use a lot of images."

We observed staff supporting people with a range of communication needs and saw that they were familiar and adept at using people's preferred means of communication. We observed staff communicating effectively with people using the service both verbally and non-verbally by writing things down or using picture cards. We saw that people using the service were supported to make their own decisions around how their rooms were decorated, the food they ate, the clothing they wore and the support provided to pursue individual interests. A health and social care professional told us "[Name] does have a great deal of

opportunity to say what they want and staff do listen."

Care and support provided in communal areas maintained people's dignity. We observed that people's bedroom doors were closed when staff were assisting with personal care and staff knocked on people's door before entering their rooms. Staff we spoke with understood the importance of maintaining people's privacy and dignity, with one member of staff saying "We take people to the bathroom or bedroom. We take a bathrobe, close the curtains and close the doors. We are discreet and work with them and treat people how you would want to be treated yourself." Another member of staff told us "We don't talk about people in front of others" and we observed that conversations and support provided in communal areas was appropriate and respectful.

Good

Is the service responsive?

Our findings

We reviewed four people's care plans and saw that their needs were assessed and care plans put in place to guide staff on how best to meet those needs. We saw care plans contained personalised information about people's needs incorporating details about people's particular likes and dislikes about how those needs should be met.

Care plans included a one page profile detailing 'What is important to [Name]', 'What people like and admire about me' and 'How best to support me'. We saw that these contained key person centred information about that individual as a quick reference guide to assist staff when providing care and support.

Staff we spoke with were knowledgeable about people's needs and were able to tell us person centred information about the likes, dislikes, hobbies and interests of the people they were supporting. We observed a high standard of person centred care being delivered in the supported living schemes we visited and found that staff were attentive and responsive throughout our inspection.

We identified numerous examples of very positive person centred care being delivered. For example, at one of the supporting living bungalows we visited, a person using the service required a pureed diet due to swallowing difficulties. Staff showed us how they had introduced a 'dining with dignity' scheme, which involved serving the pureed food in a way that resembled its original shape so that the person using the service could identify what they were eating. They showed us how they had sought advice and guidance from a range of sources including the person's Speech and Language Therapist in planning and delivering this support. This was an example of good person centred care.

Relatives we spoke with told us that people's care needs were reviewed annually. Although we saw some minor examples where care plans were behind on their annual review date or details needed updating, care plans and risk assessments were generally up-to-date and we saw evidence that they had been updated where people's needs had changed. A member of staff said "We were told by managers to tell them if the care plans are out of date, the care plans do get updated a lot." We also saw that a new quality assurance tool had been introduced which recorded when a person's care plan had last been reviewed so that the registered manager could track and ensure that care plan reviews were completed in a timely manner in the future.

People using the service told us they were able to do the things they liked and were supported to engage in activities and access their wider community. One person we spoke with told us "I go bowling, shopping, out for lunch and baking." We observed other people using the service being supported to pursue their own hobbies or interests within the supported living houses and bungalows we visited. We also saw people being supported to go out. Care plans contained details about the activities people enjoyed and records documented trips out and support provided to pursue hobbies and interests.

People we spoke with told us that they felt comfortable and safe raising concerns with the managers at The Wilf Ward Family Trust Domiciliary Care York. The registered provider had a policy and procedure in place

outlining how they managed and responded to complaints. Records showed that there had been five compliments and six complaints received in 2015. We reviewed a log book used by the registered manager to record when complaints had been received, whether any safeguarding concerns had been identified and the date the complaint was resolved. We noted that it did not record the outcome of the complaint or details of how it had been resolved. The registered manager told us that complaints were addressed and then records sent to the registered provider for them to collate and analyse. We asked the registered manager to send us details of how two specific complaints were dealt with and saw that written responses were provided to address the concerns raised. This showed us that the service was taking appropriate steps to address complaints.

Good

Is the service well-led?

Our findings

This location is required to have a registered manager as a condition of registration. There was a registered manager in post at the time of our inspection and in this respect the registered provider was meeting this condition of their registration. The registered manager was supported by two deputy regional managers. A manager or assistant manager was then responsible for each supported living house, flat or bungalow depending on the size of the service and the needs of people living there.

People using the service told us "I like living here" and "I like it here." We observed other people using the service to be content and at ease in their surroundings indicating they were happy with the care and support provided. We asked relatives of people using the service if they thought it was well-led. Feedback we received was generally positive with one person commenting "They're marvellous carers, great organisation."

Staff we spoke with said "I think it is a very well managed service. [Name] is very knowledgeable and approachable" and "It's a well-run service."

However, feedback was not consistently positive with a relative telling us "There's good and bad days with the care, it's inconsistent with changing managers and different staff"; whilst a member of staff told us "Every time we get a new manager they have a different approach to the rota" and explained how there had been a lot of changes which could be frustrating. The registered manager and deputy regional manager explained that there had been some changes with staffing and management and that this had inevitably caused a degree of uncertainty, however, they explained that steps were being taken to proactively address these issues and concerns.

Where concerns had been identified at one of the supported living houses, we saw that a new medication policy had been introduced and more regular team meetings held to improve communication. Staff we spoke with at this service told us "Morale was bad, but the team we have got now is brilliant" and "Compared to what it was it is miles better, we are working as a team now." Other staff told us that communication had improved and that the level of support from management had increased. Meanwhile the registered manager showed us a new audit tool, which had recently been introduced to collate information from separate audits and address gaps that had been identified in the quality assurance process. This example showed us that the service was well-led. Whilst there had been issues at one of the supported living services we visited, positive steps had been taken to address those concerns and these were seen to be effective by the staff working there. This was also evidenced in the reduction in the number of medication errors occurring. Meanwhile systems had been introduced to further develop the quality assurance and monitoring process to more closely monitor and identify concerns in the future.

Staff we spoke with told us that they felt supported in their role, that they were listened to and management were approachable if they had concerns. One member of staff told us they were asked for suggestions for improvements to the service in supervision sessions. Another member of staff said "If you put an idea to management they do listen to you" and gave an example of how it was suggested the rotas were changed so

more staff were available in the morning, when one person using the service preferred to go out. This showed us that there was effective communication and that changes and improvements were made when problems were identified.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. Information provided in response to identified concerns showed that the registered manager and registered provider were robust and proactive in addressing concerns.

We asked for a variety of records and documents during our inspection. We found these were stored securely, generally well maintained and up-to-date. We reviewed the quality assurance systems. Each supported living service returned a weekly report to the registered manager with details about staffing levels, agency used, specific issues relating to anyone using the service, any accidents, incidents or safeguarding concerns, compliments, complaints, medication errors and any health and safety issues. The registered manager told us this information allowed them to monitor and gain an overview of the care and support provided at the fifteen supported living services.

The registered manager had recently introduced a monthly tracker tool to record when they completed a quality assurance visit to the service, when the last team meeting was, to gather updates regarding staff training, to monitor when a person's care plan was last reviewed and identify when monthly reports had not been returned. This showed us that the registered manager was continually developing the systems used to monitor the quality of the service and to drive improvements.

In addition to gathering weekly and monthly information, the registered manager told us that quarterly audits were completed at each supported living service to monitor all aspects of the care and support provided. These covered topics including health and safety, support planning, a review of daily records, risk assessments and medication procedures. These were completed by another manager visiting that supported living service. We saw examples of quarterly audits completed and saw that action plans were implemented where changes or improvements were identified as needed. We spoke with the registered manager about adding additional information to these audits to indicate who was responsible for completing actions and a timescale so that further checks could be completed to ensure that issues had been resolved.

The registered manager showed us a relative's survey that had been completed in 2015 to gather feedback about the care and support provided. This had been sent to 36 people and 19 had responded. Feedback from this had been collated and an overview and analysis provided to communicate the results to those involved. Feedback from this survey was positive and showed that relatives and carers were happy with the care and support provided by the Wilf Ward Family Trust. We saw that a service user survey had last been completed in 2014; however, the registered manager showed us an accessible survey that was being developed and was due to be sent out to gather feedback from people using the service.

The registered manager showed us minutes of area leadership meetings held monthly. Minutes of these meetings showed that learning and development were discussed, medication audits, recruitments, action plans, the local authority quality assurance visits. This showed us that team meetings were used to communicate information discuss areas of concerns or where action or improvements were required.

We asked the registered manager how they kept up-to-date with relevant changes in legislation and guidance on best practice. They told us that the Wilf Ward Family Trust was a member of the Voluntary

Organisations Disability Group (VODG) an organisation that promotes best practice and provides information through regular news and policy briefings. The registered manager told us that they also received information internally through their learning and development team and externally through information produced by the Care Quality Commission.