Clearwater Care (Hackney) Limited

Clearwater Care Group

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

Clearwater Care Group is a supported living service that is registered to provide personal care. At the time of our inspection there were seven people using the service. The service's office is located in Peterborough. The service supports people living in Peterborough, Yaxley and Kettering.

This announced inspection took place on 13 September 2016.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection the registered manager was on leave. A service manager was in post providing day to day management support.

Staff had been trained about safeguarding people and knew how to recognise any potential signs of harm. Risk assessments were up to date and helped staff manage any potential risks to people. Appropriate behavioural management strategies were in place to help reduce any potential risks to keep people safe. A sufficient number of skilled, safely recruited and competent staff were in post.

Staff who had been trained and deemed competent, administered people's medicines safely including medicines prescribed to be given 'when required'. People's medicines were managed and stored safely.

Staff were provided with training deemed mandatory by the provider as well as subject specific training according to people's needs. An effective induction, supervision and mentoring process was in place to support staff in a positive way.

Systems were in place to support people in the event of an emergency such as need to evacuate the premises.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service's manager, team leader and care staff were knowledgeable about if and when a decision needed to be made that were in people's best interests.

People were supported by, and they had to access to, those health care professionals and services that they required. People were encouraged and supported to have a healthy balanced diet and adequate hydration according to their needs.

People experienced care that was dignified and compassionate. Staff put people's needs first and foremost. Advocacy arrangements were used to support those people who had need of this support.

People were involved as much as practicable in developing and reviewing their care plans. Information contained in each person's care plan was detailed and up to date. Staff respected people's preferences and individual circumstances. People were supported with various opportunities to be as independent as practicable with a wide range of hobbies and interests.

People, their relatives and staff had access to a complaints process which was provided in an accessible format. People, relatives, health care professionals and staff were encouraged to provide their views on the quality of the service and the care that it provided.

A range of effective audit and quality assurance procedures were in place. This was to help identify what worked well and any area that did not work as well as making any improvements necessary.

The management team fostered and supported an open and honest culture within the staff team. Opportunities to learn from accidents and incidents were taken at every opportunity. People were given many opportunities by the management team and staff to enable them to access and participate in the local community.

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 knowledgeable about recognising signs of harm and they knew who they could report this to if required. This helped people to be safe.

People were supported with their needs by a sufficient number of safely recruited, qualified and competent staff.

Accidents and incidents were recorded and acted upon to reduce the risk of harm.

People were safely supported with the administration of their prescribed medicines.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge they required to meet people's needs.

People were supported and encouraged to make decisions about their care and how they lived their lives.

People were supported to access health care services and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were encouraged to be as independent as they wanted to be.

People were cared for compassionately by staff who respected people's rights, independence and how each person communicated.

People could use the support of an advocate if they preferred or needed this.

Is the service responsive?

Good

The service was responsive.

People's care and supported living needs were identified, responded to and this had a positive impact to each person's life.

People accessed and benefitted from a wide range of hobbies and social stimulation.

People's, relatives' and staff's concerns and complaints were investigated and acted upon.

Is the service well-led?

Good

The service was well-led.

People were involved in, and contributed to the way the service was run. There were arrangements in place to listen to what people, relatives and staff had to say.

The management of the service fostered and supported an open and honest culture within the staff team.

Effective quality assurance and audit processes and procedures were in place and these were used to help drive improvements.

Clearwater Care Group

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced inspection took place on 13 September 2016 and was undertaken by one inspector. We gave the provider 24 hours' notice as some people had anxieties which could be triggered by visitors they were not aware of.

Before the inspection we looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with two people, two relatives, the Director of operations, a team leader and three care staff.

We observed people's care to assist us in understanding the quality of care people received. This was because some people did not communicate in a verbal way.

We looked at three people's care records, the minutes of staff and managers' meetings. We also looked at medicine administration and management records as well as records in relation to the management of the service. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints and quality assurance records.

Good

Is the service safe?

Our findings

Staff were skilled in recognising, reporting and acting upon any, or potential incidences of harm. Staff also possessed a good understanding of the procedures to follow to report their, or peoples, concerns. One person told us that they felt safe. They said that this was because, "there is always staff around and I go out when I want with them." One staff member said after explaining what abuse could mean, "There are many different types of abuse and I would call the (registered) manager or provider, CQC (Care Quality Commission) and the local authority as well as the police if necessary." We saw that information was provided to people so that they could raise their concerns such as through sign language, picture cards or objects of reference. In addition, staff had access to the local authorities contact details. Staff told us that people could express their anxieties if they had been harmed in any way such as being withdrawn, tearful or just not their usual self. This showed us that the service considered people's safety and that they would act on any concerns if required.

The Director of Operations told us and records viewed confirmed that only none physical intervention methods were used. These none physical de-escalation helped ensure people's anxieties were managed to the benefit of the person before it had the potential for any harm. One person told us, "If I need their [staff's] help they come quickly and then ask me what I want. I get anxious if I have to wait." The person confirmed to us that they had not had to wait more than a few minutes for staff.

Strategies and procedures were in place for the management of risks to people. For example, whilst out in the community, safe access to the internet, communications, as well as ensuring people's homes were a safe place to live and be supported in. This was to help ensure people were kept as safe as reasonably practicable. Risk assessments were kept under review and had been amended when required. For example, if a person's health condition and their levels of independence had improved. A team leader told us, "Some people need clear boundaries which staff need to adhere to. This helps the person understand the consequences of their actions." We saw how various systems had been used to make people aware of their actions and that as a result of these there had not been any repetition of the event. One relative said, "Since living at Clearwaters my [family member] has much less behaviours. I couldn't manage on my own if they lived at home. It is good to see them becoming much more grown up."

Each person had a personal evacuation plan in place that had been tailored to the safety of the person. This plan included information should people have to move to a new location such as a fire or flood. Other information was available if people needed to be urgently admitted to hospital such as those situations which could cause a person anxieties and calming or prevention strategies.

A comprehensive system was in place for the identification and management of accidents and incidents. The Director of operations showed us from their records how each occurrence was investigated, analysed for trends and the actions that were taken to limit the potential for recurrence. This included people experiencing a seizure, a fall, behaviours which could challenge others and any safeguarding incidents. We found that actions taken included training in none physical interventions as well as the dismissal of staff who had not maintained the standards of care required. Other actions included changes to the way people

were supported such as the number of staff and the calming strategies for people with behaviours which could challenge others. For example, by giving people some individual time to calm down before staff approached them.

From our observations of people's care, speaking with people, relatives and staff we found that there was sufficient staff to meet people's needs. One person when asked if they felt safe when they went out, responded positively by nodding and smiling, signing yes and pointing to the staff that supported them safely. One relative told us, "If I wasn't confident about my [family member's] safety in any way I would have them live with me but I have never had any concerns." Another relative said, "The supply of staff is fantastic. My [family member] goes out a lot as they tell me what they have been up to." This showed us that that there were systems in place to help ensure people were cared for in a safe way as much as practicable. We observed that people's requests for assistance as well as staff's understanding of people who did not communicate in a verbal way were responded to promptly.

One relative said, "The difference having enough staff make is that compared with the previous provider my [family member] goes out when they want and not when staff say." Staff told us that there was sufficient staff. One staff member said, "It is nice to be able to respond to people's request to go out with us and also having the flexibility to respond to people's preferences. It is their life and we are here to help them live it." A team leader told us, "If they [staff] call in sick we can, in the main, cover these types of absence from existing staff, swapping shifts, extra shifts or agency [staff] if there are no other alternatives." The Director of operations said, "[Registered manager] and [service manager] can step in if it is necessary or urgent." One relative told us, "There is always staff there when we visit to pick up [family member]." This showed us that there were systems in place to ensure that staff were able to safely meet people's needs.

One staff member told us, "Although some people choose to go home to see and be with parents knowing what makes people feel and be safe as well as being there for people is what is important. We can't replace a parents' ways but as they [people] grow in confidence and independence we are there to support them and to keep people safe."

We found that the provider's systems and procedures helped ensure that only those staff deemed suitable were offered employment with the service. This was evidenced to us by the records that were in place and by what staff told us. One staff member told us, "I had to bring in my qualifications, proof of address, my driving licence and two references including one from my most recent employer. Another staff member described their job interview by saying, "[Registered manager] did my interview and she explored my knowledge of various situations as well as my background and reasons for wanting to work at Clearwaters." We found that checks that had been satisfactorily completed and included evidence of photographic identity as well as previous employment history and the explanation of any gaps. Other checks included a Disclosure and Barring Service check which had been carried out prior to staff commencing their role at the service. This was to ensure that the service had only employed those staff who were suitable. This demonstrated to us that the systems in place helped ensure that staff with the right skills and aptitude were employed.

Staff were regularly trained and assessed as being competent in medicines administration. Staff and management explained to us what people's medicines were for, how and when to administer them as well as being aware of any potential side effects. We observed that medicines administration and management was in line with current guidance. This included the storage, disposal and protocols for medicines that needed to be administered as and when required. People were supported to be as independent as possible with their medicines.

Good

Is the service effective?

Our findings

An effective and robust programme of staff development was in place to support staff with their training and gaining of qualifications. Staff's development started the moment they commenced their induction. One staff member told us, "When I first started I had to complete on-line training as well as on the job training. I shadowed more experienced staff until I was satisfied and confident to undertake my job with little or no support. I was really well supported and I could ask for more help if there was ever anything that I was unsure about."

All staff we spoke with had been trained in those subjects that were essential for the people they supported. For example, positive behavioural therapy, sign language, autism and epilepsy. At the people's homes we visited we saw how the team leader introduced us to people and explained what we would like to do and see. We also observed how staff considered people's health conditions in the way they communicated such as with sign language. All staff we spoke with commented favourably about the support and training they received. One staff member said, "I only have basic sign language but some staff have a higher level it depends on the people we support. I have had training on subjects including health and safety, infection prevention and control, food hygiene, fire safety, safeguarding as well as the Mental Capacity Act [2005] and DoLS (Deprivation of Liberty Safeguards). A relative told us, "I think that the staff know what they are doing as my [family member] would have no hesitation telling me if they didn't do things the way my [family member] likes."

We found that a staff training programme was in place as well as staff being provided with training from the local authority. We saw and staff confirmed to us the training and the refresher training that they had undertaken. One staff member told us, "I had a very comprehensive induction. All the mandatory subjects such as first aid, moving and handling and basic life support. I have also had specific training in epilepsy care, Makaton [signs (gestures) and symbols used with speech], sign language and positive behavioural therapy." We found that Staff had the skills and knowledge they required to meet people's needs and promote their independence.

Formal and regular supervision for all staff was in place and this was planned for the year. Staff told us and we found that their planned supervisions were very much a two way process. One staff member told us, "If there is anything affecting me, people or my work I can discuss this with [service manager] and they are really good at sorting things out and being there when I need them." Another staff member told us that their team leader could be contacted for advice at any time as well as seeking their views when they visited the places where people lived. We observed how staff's support had a positive impact on the way people such as staff who got on well with the person. This resulted in the person achieving their potential in a more confident way.

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

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and other legislation. The Director of operations, in conjunction with the registered, and service, manager ensured that any person who lacked capacity to make informed decisions was identified at an early stage. This was so that the necessary process could be followed and any restrictions on people's liberty were as minimal as practicable. Although we found and management and staff confirmed there was no person using the service who lacked capacity, all staff were aware of those circumstances where a Deprivation of Liberty Safeguard may need to be applied for to the Court of Protection. We checked whether the service was working within the principles of the MCA. We found that all staff understood what the five key principles of the MCA were and how to apply these. For example, by acknowledging that people had the right to make decisions, even if people did not always fully understand the consequences of their decisions.

Staff had received training on the MCA and DoLS and where this could become applicable. For example, always respecting people's choices but explaining what the consequences of these might be. One staff member said, "As some people need assistance to choose what to wear or eat we help them make wise choices as much as practicable. The staff then told us about the various health professionals and organisations that could contribute to a best interest decision. For example the person's GP and social worker. This showed us that any assistance to help people make decisions were in line with the MCA and DoLS codes of practice.

We found from the records we viewed, people and staff we spoke with that people could choose their meals as well as being supported to go shopping for this. Staff told us, "By preparing a shopping list with people it helps them buy healthy options but if they sometimes like a take away or less healthy option they can have this. We always encourage healthy options but we can't force people to eat things they may not like. We found that where required a dietician and speech and language therapist had been involved with people's care. For example, for those people at risk of choking or maintaining a healthy weight. One person told us about the foods they liked such as spaghetti bolognese and pizzas and having home cooked food as well as being able to eat out. Regular checks were in place to monitor people's weight and assist in identifying if any referrals to a health care professional such as a dietician was required. People could be assured that their health and nutritional needs would be safely met.

We found that people's health care needs had been met with a variety of support. This was from the appropriate health care professionals such as a dentist and physiotherapist and attendance at well man/woman clinics. This was to ensure that any risks associated with people's health were minimised and also to improve people's independent living skills. We saw that the advice, guidance and instruction from health care professionals had been followed such as people's nutritional support. We also saw how people were supported to attend their health care appointments. We found that staff were mindful of any anxieties that these visits could cause and how to prevent them.

Good

Is the service caring?

Our findings

People's relatives we spoke with were complimentary about the care that their family members received. One relative said, "They [staff] are very kind. If they weren't I would know straight away as my [family member] would be very quiet and not their usual bubbly self." Another relative told us, "If I wasn't happy about the standard of care and being confident that my loved one was being well cared for I wouldn't let them live there. But, in four years I have never worried because my family member] has flourished." One person told us that staff cared for them in a caring manner by saying, "They look after me well. I need help (with washing) but they are all nice."

Each person had a record of their achievements as well as their day to day activities. This was so that staff could identify what care worked well for each person. One relative said, "My [family member] has a real affinity with their care worker. They will often tell the key worker things they wouldn't discuss with me. My [family member] has matured so well and can do so many activities (because of the care that had been provided)."

We observed and staff told us that they only entered people's rooms after knocking and asking, if it was "alright if I come in"? We observed how staff knocked on people's room door, asked if it was alright to speak with them and if they could check people's prescribed medicines. We heard staff addressing people by their names and also showing respect for the person's privacy and dignity. For example by being discreet in the way they supported people. One person told us about their preferences for a female staff member by saying, "They treat me gently." One relative told us, "They [staff] absolutely make sure my [family member] is cared for in a dignified way." Another relative said, "I know that letting go of the apron strings was not easy but from what I see my [family member] flourishes. The house they live in is beautiful and well kept. I couldn't wish for a nicer place for my [family member] to live."

Staff told us how people's dignity was respected such as by covering people with a towel, having a conversation, running the bath first and letting people do as much for themselves as possible. One staff member said, "I always make sure the curtains are closed that the door is shut and everything that is needed such as clothes are all in place." Another staff member told us, "Just simple things such as having a conversation can make it more dignified as well as keep people calm and relaxed."

People's care plans and records were held securely and staff ensured that these were only reviewed or read in private. Our observations confirmed that staff were considerate of people's needs, listened to what people communicated through sign language, facial expressions, hand gestures and vocalisations. We also saw how staff gave each person the time they needed to tell staff in their own way how they were feeling or if they wanted anything such as pain relief. We saw how staff spoke or communicated in a sensitive but clear manner. This was so that people could understand the options that they had been given such as baking a cake or going out to a club. We saw that staff spent time with each person either in a communal lounge, in the privacy of the person's room or letting people spend time doing their favourite pastimes. One person told us that they had bought a comedy film and that they would watch it later that day.

The staff made sure people felt that they were listened to in various ways. This was through assistive technology, sign language, verbal communications as well as body language and behaviours. One staff member told us, "You can tell if they [people] aren't happy as they aren't willing to do what they would normally do. I have a chat and talk about the positives of doing something and the benefits to the person. Sometimes you have to leave them for a while and try again." We saw that staff were considerate about people's initial responses but also encouraged people in a sensitive and caring way. For example, by being positive in their tone of voice.

Staff knew the people they cared for very well. This was due to the time they had cared for people as well as having an understanding of younger adults care and support needs as well as social activities. Examples we found and staff gave us of people's likes and dislikes included their favourite films, having a bath or shower, listening to music or just relaxing in their room. We saw that people's comments and vocalisations were of contentment and happiness. One person when we asked them which staff were nice they pointed to them and laughed. Staff confirmed to us that the person was happy, having a good day and they would communicate if they weren't happy.

Staff said, "The care plans are as detailed as required. If people benefited from easy read care plans and pictures then this is what happens. When new staff start or on rare occasions, agency, then there is [enough information] to be able to care for the person based on their individual needs." Examples of this included assistance with health care appointments. We saw that staff cared for people in the person's preferred way such as with day to day contact, conversations as well as more formal reviews with relatives or advocacy.

The Director of Operations, team leader and staff confirmed to us, and we saw, that people could contact relatives. This was when the person wanted to as well as occasions when they wished to spend time with their family. One relative said, "Knowing my [family member] is in a place they love means the world to me."

We found that some people had parents as their representative who acted as an advocate for them if required. Other advocacy had also been provided through people's social worker. This was to help ensure that care was in any person's best interests. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. All management and staff were aware of when advocacy was required. This showed us that people's wishes, needs and preferences would be respected if people were not able to speak up for themselves.

Good

Is the service responsive?

Our findings

Prior to people commencing use of the service their needs were assessed. This was to help ensure that the registered manager and their staff were able to support the person to safely meet their needs and preferences. Other information, including that from the person, any previous placements and health care support were also used. This was used to help identify those individual aspects of people's lives that were important. One person told us, "I like [type of] films as well as anything that makes me laugh." A relative said that the service considered those aspects of people's lives which helped their family member to become as independent as possible. For example, by accessing those pastimes which developed their daily living skills such as helping with the cooking.

Each person had a key worker who was responsible for particular details of people's care and care planning. These key workers, with staff's assistance, kept care plans up to date and informed relatives about any changes or particular achievements that relatives felt useful such as health care interventions (where the person agreed to share this information).

Relatives we spoke with gave differing views about how much independence they felt or saw their family members had. However, we found that staff understood people's requests and choices, and as a result of this they respected people's preferences. This was also whilst using established boundaries that encouraged people as much as practicable to be independent. We found that a wide range of social stimulation was offered and people and their relatives confirmed that these opportunities had been taken up. People led busy social lives as well as having time for hobbies, pastimes and interests. A team leader told us that the range of activities people took part in included, trampolining, hydrotherapy, bowling, various peer group clubs for people with sensory impairments, speaking with relatives using electronic video links, gardening, arts and crafts and sailing and cycling at local parks. One relative told us, "They [staff] are very good at getting [family member] to do things. I don't know how they do at but it is so reassuring to know that my [family member] keeps active." Another relative said, "The difference they [staff] have made to my [family member's] independence is huge." They gave us examples of their family member's achievements such as being an outgoing person who now did all those activities any person could do. As a result of staff's interventions this had enabled people to live an independent life with only limited support and prompts from staff.

Other ways staff supported people with their interests was by assistance to access the community using taxis, public transport as well as walking. This was so that people could participate in their chosen hobbies and pastimes. For example, swimming, shopping, visiting peer group clubs, marshal art classes as well as attending presentations from various organisations such as a cricket club and the Fire Service. People also attended local country parks to go sailing, cycling and fishing and play their favourite computer games and use video communications. One relative told us, "I would not have the time to support my [family member] the way they [staff] do. It is reassuring that they [family member] can do so many things with their time." This showed us that people were supported to be independent and lead fulfilling lives.

For some people who could not safely access the community on their own, additional staffing had been put

in place. This had enabled the person to access the community when they wanted. This also enabled them to meet friends and peers who shared similar hobbies and interests.

People's care plans were reviewed at least annually but also more frequently if people's care needs changed. We saw that care plans were in a format that made them accessible such as easy read or pictorial format if the person benefited or preferred this option. This was to help staff provide people's care in a more person centred manner. For example, in the person's ability to make informed choices about their preferences such as a bath or shower, the clothes they wore as well as the time they liked to get up or go to bed. People's current care plans identified the complexities of people's care but also how in a detailed way that these needs were to be met to maximise each person's potential.

People's views including those with limited verbal or non-verbal communication skills were frequently sought and considered. This was by using sign, or body, language and assistive technology as well as regular contact with staff. People's views and information that staff had gathered were then used to determine what worked well and what did not work quite so well. This showed us that the provider considered people's views in as many ways as practicable. All management and staff knew how to respond to complaints should they ever have a need. We found that complaints had been investigated, acted upon and resolved as far as reasonably practicable. One relative told us, "There was an issue with damp in my [family member's] room and they [the provider's representative] contacted the landlord straight away and the matter was sorted very quickly, to my [family member's] satisfaction." People were actively encouraged to give their views and raise concerns or make suggestions before they had the potential to become a complaint. This was through people's daily contact with staff and the feedback that was provided. The Director of operations confirmed that the service manager and registered manager maintained a close working relationship with people's relatives. This was so that any concerns, changes or suggestions were identified as well as regular visits by management to people's homes.

Good

Is the service well-led?

Our findings

The service had a registered manager. At the time of our inspection they were on leave. They were supported by a service manager, team leaders and care staff. From information we hold and our findings at this inspection we found, that in conjunction with the support and training they provided to staff, the registered manager was aware of their responsibilities.

People, relatives', staff members' and health care professionals' views about developing and improving the service were frequently sought in the most appropriate way. This included people's non-verbal comments through supported communications including Makaton, sign language, vocalisations, pointing to objects of reference and facial expressions. The provider had recently completed a quality assurance questionnaire. The results of this were mainly positive. A full analysis of this audit was due on 30 September 2016. One relative told us, "I always speak with the staff and if there is something they are not able to resolve I can meet the service manager. They [service manager] are very keen to make sure that the support for my [family member] is as good as it can be given the constraints outside their [the provider's] control." Another relative said that the place their family member lived was "better than being at home". They said that this was because of the teamwork in the way care was provided. Both relatives told us that they felt listened to and that the service and its staff acted in their family member's best interests.

All staff and the team leader we spoke with told us that the registered manager, service manager and management were very approachable. One team leader said, "I visit people's homes regularly and check to make sure that the right standards of care are being adhered to. If I come across any situation that I can't resolve I can speak with [service] manager and the registered manager if they weren't on leave. I feel totally supported." During our visits to people's homes we saw that the team leader knew their staff well. This was by their positive interactions with staff and people.

All staff told us that they received appropriate support on a daily basis. This was as well as being lead and guided by more experienced staff and management. This helped them to be confident and placed them in the position of being able to provide people's care to the required standards. This standard was set in the provider's values of how staff needed to conduct themselves. Our observations, records we looked at and comments we received from people showed us that staff upheld these values. One staff member said, "I feel very much supported by my managers. They are very supportive and they have an open door policy where I can speak to them at any time. We are also praised for what we do well." A relative told us, "They [the provider] allows me to have an input but puts my [family member] first." One person said, "I love living here. They [staff] are all nice."

Many links were maintained with the local community and included but were not limited to visiting a garden centre, going to local parks, cinemas, shopping and visits to health care appointments. One person told us, "I have been out to the dentist today and then I am going to listen to some music." Other links included those with the local Fire Service and access to social media and video communications.

We found that there were robust and effective audit and quality assurance processes in place. This was in

the form of spot checks, staff supervision and appraisals and an annual schedule for improvement. This schedule included subjects such as, but not limited to, reviews of actions taken for any incidents, staff driving licence checks, fire safety checks, hygiene standards, care plan review effectiveness and that the CQC had been notified about all events that by law we are required to be told about. Where actions had been identified there was a date for this to be completed as well as a staff member holding the responsibility for the actions' timely completion. We saw that appropriate action was taken where issues had been identified. For example, making sure that staff accurately completed medicines' administration records and that they wore personal protective equipment.

Management staff kept themselves fully aware of the day to day staff culture and their adherence to the provider's policies such as safeguarding and mobile phone usage. This was by daily contact with people, relatives and health care professionals when required. In addition, the Director of operations was provided with a weekly report of all relevant areas which managers reported on. In addition the Group Supported Living Manager does a separate report to the Senior Management Team. The Group Supported Living Manager reports to the board reports monthly.Staff confirmed that the support they received enabled them to do their job effectively. One staff member told us, "They [registered and service managers] are fully committed to people and making sure we support people to live their lives to the full and achieve their potential. It is not unusual for the managers to work alongside or with us."

The Director of operations and service manager had a clear understanding about the key challenges in running and managing the service. For example, in recruiting staff with the right skills and attitude and providing training that met staff's and people's needs. The Director of operations told us, "We do recruit staff who have not previously worked in care. It is not just about numbers or skills it is as much about staff wanting to make a difference to people's lives. It is not always easy or perfect but having the right systems in place really helps." We saw that the management checks also included those for the correct application of the MCA and DoLS and the circumstances which could give rise to the applications of this legislation. This and other information was reported to the provider's senior management team. This was to help ensure that the correct governance arrangements were in place. Our findings at this inspection confirmed that they were. This was also supported by a monthly governance newsletter from management to staff and how standards of care needed to be maintained.

Staff meetings for each service were held as well as management meetings covering all the provider's services. These meetings were planned to share best and good practice as well as learning from any incidents that occurred such as improvements in the way people's anxieties or behaviours which could challenge had reduced and the reasons for this. Other information was shared with managers about improvements in staff's completion of training and refreshers for this. Staff also recorded in a daily diary people's activities of daily living and other useful information such as their achievements and health care appointments. This diary was used to inform people's care plans and any subsequent changes or improvements at a shift handover. At the daily handover meeting this diary helped staff to share and be aware of people's changing or new care needs such as hospital visits or changes to prescribed medicines. This information was audited to ensure that records were accurate and reflected events correctly. This helped identify any potential areas for improvement as well as those aspects of people's care that worked well.