Lifeways Independent Living Alliance Limited

Independent Living Alliance - Manchester

Inspection report

451 Victoria Avenue
Manchester
Lancashire
M9 8PJ

Tel: 07811133259
Website: www.ila.uk.com

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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

Independent Living Alliance – Manchester is a community based service which provides supported living services to four people in one property. The service was previously inspected in 2014 where the provider was found to be complying with the outcomes we inspected. This inspection took place on 11 October 2016 and was announced.

There was a registered manager in post who had been registered with the Care Quality Commission (CQC) to carry on a regulated activity since July 2015. A registered manager is a person who has registered with 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.

The people we visited told us they were happy living in their home and felt safe being supported by the staff both at home and in the community. The registered manager and the staff had a good understanding of safeguarding procedures. They were fully aware of their responsibilities with regards to protecting people from abuse or improper treatment. Incidents of a safeguarding nature had been dealt with appropriately and referred to the local authority. Policies and procedures were in place to ensure the service was operated well.

There were enough staff employed to ensure the people's needs were met. Team leaders and service managers were employed throughout the provider's organisation to ensure all services were run safely and effectively. At the time of inspecting this service, there was a vacant service manager's post. The provider had a rolling recruitment programme to build up a bank of care workers to cover in the event of absences across all services. There was a robust recruitment process in place and we confirmed this process was followed when we reviewed staff records. Staff told us they worked regular shifts and we saw their rotas were planned in advance. This demonstrated people received a flexible, consistent and reliable service.

Care records were very person-centred and contained personalised information. Individual care needs had been assessed and the risks people faced were documented with strategies and actions for staff to follow in order to mitigate those risks. We saw care records were regularly reviewed and updated.

Accidents, incidents and near misses were recorded, investigated, reviewed and monitored by the team leader and overseen by the registered manager. The registered manager was aware of her responsibility to report certain incidents to external bodies, such as the local authority and CQC as necessary. However we found one notifiable incident which had not been sent to CQC. We asked the registered manager to do this in retrospect, which she did.

Medicines were managed well and staff demonstrated that best practice guidance was followed. We observed staff administer medicines in a safe, timely and hygienic manner. Medicine Administration Records (MARs) were used to record when assistance was given. We saw these were legible, accurate and up to date.

The provider had an up to date induction process in place and staff records confirmed they had completed the induction and had shadowed experienced workers. Training in topics which the provider deemed mandatory had been undertaken, such as safeguarding, safe handling of medicines and food hygiene. Specific training in autism awareness, epilepsy and positive behaviour management had been resourced as this was relevant to meet people's needs. Formal staff supervision sessions, including a probationary review had taken place as well as annual appraisals and regular job chats.

Staff meetings were held every three months with the care workers; monthly team leaders and service managers meetings took place across the provider's organisation. The staff we spoke with told us they felt supported and valued at work by the management team.

The registered manager and staff displayed an understanding of the Mental Capacity Act 2005 (MCA) and their own responsibilities within its principles; staff had completed MCA training and people's mental capacity had been assessed. There was evidence that decisions had been made in a person's best interests with the involvement of relevant others, including through the Court of Protection.

Staff supported people to maintain a well-balanced diet. Most people were supported to shop for and prepare meals depending on their abilities. People were given choices and assisted to plan menus for the week ahead. Staff had been made aware of allergies and food intolerances as well as likes and dislikes. We saw evidence that staff involved external professionals as required to provide input into people's care.

The atmosphere in the service was calm and relaxed. The staff we spoke with were friendly, caring and professional. They spoke with affection about people they supported and obviously knew them very well. The information they told us matched the information we read in people's support plans. Staff told us how they respected people's privacy and maintained their dignity during personal care and we observed them speaking politely to people throughout the inspection. Daily notes recorded by staff reflected caring and respectful values. 'Personal choice' reviews were completed with people on a regular basis. These reviews measured the person's involvement in choices and decisions.

There had been no complaints made about the service. We reviewed the provider's complaints policy and saw the registered manager had ensured the complaints procedure was shared with people and on display in communal areas. The people we spoke with told us they had no complaints.

There was evidence that the service sought the views of people and their relatives about the service they received. Satisfaction surveys were issued to people and staff for their opinions. Other stakeholders, such as local authority care managers and external professionals were also asked for feedback.

The records we reviewed were accurate and up to date. Records containing people's personal information were stored securely. Staff records were kept at the provider's office. Regular audits of the service were carried out by the team leader and evaluated by the registered manager. Provider audits were carried out by representatives from the provider organisation. This demonstrated the provider and the registered manager had oversight of the service and they monitored it for safety and quality.

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.

Risk assessments were in place and individual needs had been thoroughly assessed. Safeguarding concerns, incidents and accidents were investigated and reported to the relevant external agencies.

Staff recruitment was robust and potential employees were appropriately vetted before starting work.

People indicated they felt safe living at home with help from their care workers and medicines were managed in safely.

Is the service effective?

Good

The service was effective.

Staff were skilled and knowledgeable and were supported by the registered manager through training, supervision, annual appraisal and team meetings to help staff meet people's needs.

Consent to care and support was sought in relation to people's needs.

People were supported to eat and drink to ensure their health and well-being. People's general healthcare needs were met and other health professionals were involved as necessary.

Is the service caring?

Good

The service was caring.

We observed staff were friendly, caring and kind.

Staff demonstrated they maintained people's privacy and dignity, respected them and treated people as an individual.

People and relatives were involved in care planning and were offered choices and given control over their own lives.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and people's needs were assessed and regularly reviewed.

A complaints policy was in place and people were aware of how to complain.

People took part in meaningful activities.

Is the service well-led?

Good

The service was well-led.

The staff team worked well together to ensure the smooth running of the service.

Audits and checks of the service were in place to monitor it's safety and quality.

Feedback was sought from people and their relatives to ensure satisfaction of the service.

Independent Living Alliance - Manchester

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 inspection took place on 11 October 2016 and was announced. We gave the provider short notice of the inspection to ensure there would be staff available who could access the records. We also wanted the people who lived at the service to be made aware of our visit. The inspection was conducted by one adult social care inspector.

Prior to the inspection we reviewed all of the information we held about Independent Living Alliance – Manchester, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are sent to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

On this occasion, we asked for a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

During the inspection, we spoke with all four people who lived at the service who were being supported 24 hours a day by staff. We also spoke with the registered manager, a team leader and two care workers. We were able to observe care delivery in communal areas such as medicine support and mealtimes and we were invited to look into three bedrooms. We reviewed a range of care records and the records kept regarding the management of the service. This included looking at one person's care records in depth and reviewing the other three, five staff files and other records relating to the safety and quality of the service.

Good

Is the service safe?

Our findings

People appeared relaxed and comfortable in the presence of the staff and the atmosphere was calm and homely. We asked people if they felt safe and happy and they told that they were. People said, "I like it here" and "I've lived here for years – it's great".

Staff displayed an understanding of safeguarding vulnerable adults and told us how they protected people from harm and improper treatment. The staff we spoke with had no concerns about the people they supported and they were able to tell us what they would do if they suspected abuse. The provider had policies and procedures in place to support the staff with their duties and responsibilities and they provided guidance on how to report anything suspicious. Incidents of a safeguarding nature were recorded, investigated and monitored. Specific incidents which met with threshold guidance were referred to the local authority and if necessary the Care Quality Commission (CQC). The threshold was determined by the local authority and based on the severity of the incident. We reviewed these records and found them to be detailed and up to date. We found one incident had not been notified to CQC which should have been. We asked the registered manager to send us the information in retrospect, which she did.

We saw the service had assessed risks people faced in their everyday lives to help ensure their safety. This included risks involving behaviour which may challenge others, accessing the community, road safety, finances and medicines. The risk assessments contained details of hazards, the likelihood of an occurrence, existing measures in place and any further risk reduction actions which staff could take. Detailed instructions for the staff to follow in the event of an incident which helped reduce the risks were recorded well. We saw evidence that staff understood this as they had signed a statement of understanding. This meant there was a reduction in the possibility of repeat occurrences.

We reviewed two records made in the incidents and accidents file in 2016. Staff had detailed the circumstances leading up to an event; factors which added to or caused the event and the actions and strategies tried and carried out by staff. This demonstrated that staff had the ability to appropriately deal with any incidents using the least invasive actions possible, such as calming strategies, breakaway techniques, physical intervention or the use of prescription medicine (as a last resort).

There were emergency procedures in place and staff had an understanding of what was required of them in the event of an emergency. A fire risk assessment had been carried out and was regularly reviewed. Care records contained Personal Emergency Evacuation Plans (PEEP's) which detailed each person's ability to leave safely in an emergency and the level of assistance they would need from staff.

Although the premises were not the responsibility of the provider, we saw that routine safety checks were carried out. Staff supported people to report safety issues or repairs to the landlord and recorded the details in a maintenance log. The registered manager kept a record of when the landlord had carried out essential gas and electrical safety checks to ensure they were up to date. Staff checked the temperature of the hot water before use to avoid scalding and also monitored refrigerators and freezers to ensure food was stored safely.

The staff we spoke with told us they felt there were enough care workers employed by the service to manage the needs of each person. The people who used the service required one to one care whilst accessing the community. We saw some people went out with a care worker, others attended planned day care sessions and some preferred to stay at home some of the time. We saw there were enough staff deployed on the day of the inspection to meet everyone's preferences. The registered manager was in the process of recruiting for a service manager and they were building up a bank of care workers to cover absences of permanent staff. The staff team appeared to be reliable and consistent and the rotas showed that staff covered for each other when necessary. We saw staff rotas were planned in advance. This meant the registered manager was monitoring staffing levels and ensuring they were appropriate.

We examined five staff personnel files and found a robust recruitment process had been followed. Competency based interviews of potential employees had taken place, two references were obtained and verbally verified and a check with the Disclosure and Barring Service (DBS) was carried out. DBS checks ensure staff have not been subject to any actions that would bar them from working with vulnerable people. Employers use these checks to help them make safer recruitment decisions. Staff files contained evidence of an application for employment with gaps in employment history explored, an induction, shadowing of existing staff and on-going training. This demonstrated that the registered manager safely recruited staff with a variety of skills and experience and checked that they were of suitable character to meet the needs of vulnerable people. The staff we spoke with confirmed that these checks were completed prior to them commencing employment. The registered manager carried out return to work interviews following periods of sickness and offered counselling sessions to employees where appropriate. The provider had a disciplinary policy and procedure in place for when staff fell short of expectations. This showed that the registered manager continued to ensure staff were suitable to work within the service.

Medicines were well managed and stored securely. Staff accessed the medicines from a locked cabinet and supported people to take it. We discussed with staff about ordering medicines on time, storage arrangements and returning medicines to the pharmacy for disposal. The staff displayed a solid understanding of managing medicines appropriately. Records showed staff had received training in the safe handling of medicines and had routine checks carried out on their competency by the team leader.

We examined two people's medicine records. The records contained a photograph which people had given permission for. A separate consent form was signed by each person. One form was countersigned by staff as the person lacked mental capacity. Staff had signed a statement of understanding with regards to people's medical needs and the medicine risk assessment which included the reason for the medicine, the method of administration and any side effects. A care plan documented the level of assistance a person needed and highlighted known allergies. The medicine administration records (MARs) were well maintained and completed to date. There was evidence that medicine which was only needed as and when required, such as for pain relief or for reducing anxiety was recorded and monitored correctly.

Good

Is the service effective?

Our findings

The staff we spoke with told us they had attended an induction, shadowed experienced colleagues, completed training courses and had checks carried out on their competence. One staff member said, "Everyone must complete an induction and certain training courses before they even start work."

All staff had undertaken a company induction which included two shadow shifts and a day for completing e-learning. Since the introduction of the 'Care Certificate' in April 2015, all staff had completed the workbooks and had their competency signed off by the team leader. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. The provider ensured compliance with local authority contractual arrangements by resourcing training which they deemed mandatory for their staff, such as safeguarding vulnerable adults, moving and handling of people, safe handling of medicines, infection control and health and safety. Further training had been arranged in order to meet the individual needs of people who used the service, for example in autism awareness, epilepsy and positive behaviour management.

Training had been carried out using a variety of methods such as face to face sessions, e-learning and access to external training sessions delivered by the local authority. We reviewed a colour coded training matrix which the registered manager kept to record staff training and enable the team leader to monitor when staff needed refreshed. We saw that safeguarding training was scheduled to be completed next by staff who were due for an update. The staff files we looked at contained evidence of an induction, completion of training awareness courses and records of competency checks. This showed the registered manager had ensured staff had the knowledge, skills, experience and continued competence to undertake their role.

Probationary review meetings had been carried out throughout the first six months of a staff member's employment. This was followed by three monthly supervision sessions and an annual appraisal. Supervision sessions included discussions about the service and people's care needs, support required, education and development and managerial issues such as performance. Supervision was also an opportunity for staff to formally raise any issues they had. Job chats were conducted in-between supervision sessions to record an issue or a performance concern. They were also used to document discussions held following an incident or a sickness absence to ensure the well-being of the staff. This showed that staff were supported in their role and the registered manager ensured staff's continued suitability for the role.

An effective handover process was in place. Staff signed handover records at the start and end of each shift to confirm information had been communicated between teams. Support plan notes, any incidents, MAR sheets, equipment checks, temperature monitoring, maintenance logs, outstanding tasks, rotas and keys were all checked and discussed before responsibility was handed from one team leader to the next.

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

make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager and the staff we met displayed an understanding of the MCA and were working within its principals. We saw evidence in staff records that staff had received training about the MCA. There was evidence in people's care records that capacity assessments had been carried out for everyone who used the service and people's preferences had been considered regarding their care and support. The staff told us they encouraged people who lacked capacity to make small decisions but more complex decisions had been made in people's best interests with their family, a local authority care manager and other professionals as necessary. We saw an example of a best interest decision about medicine administration was recorded appropriately in one person's file.

The registered manager told us an application had been approved by the Court of Protection to restrict someone's freedom for their own safety. Staff were aware of this order and managed the person's care appropriately. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at that time because they may lack capacity to do so. In addition, three people's finances were managed through an 'Appointeeship'. An Appointeeship is a term used by the Department for Works and Pensions (DWP) which gives another person (usually a relative) the right to deal with the benefits of someone who can't manage their own financial affairs because they lack mental capacity or are severely disabled. This meant the registered manager had taken appropriate action to ensure legal processes were followed in relation to the MCA.

We saw evidence that people's consent was sought wherever possible when arranging appropriate care and treatment. In all of the care records we reviewed, we saw staff had given people the opportunity to sign consent for the staff to provide assistance. Some of the information was provided in pictorial format to help people understand the information they had been given. Where one person lacked capacity to understand the information, staff had countersigned the form to confirm they had explained the information to the person in a way they understood.

Staff supported three people to shop for, prepare and cook meals. People were able to carry out some cooking tasks where their individual ability allowed it. People were given choices and meals were prepared by staff based on likes and preferences. One staff member told us, "We do a 'come dine with me' style night and three people take it in turn to prepare and cook a meal for the others – they really enjoy that. (Person) is making hunters chicken and rice tonight." Staff were knowledgeable about people's dietary needs and were able to tell us about specific requirements such as, allergies, intolerances and diabetic needs. We saw evidence in one person's care records that a diabetic nurse was involved in order to help the person control their diabetes. We saw staff had made a referral to a dietician for the same person.

One person did not require support from the staff to manage their mealtimes. They told us they shopped for and prepared their own meals. They said, "I don't like doing 'come dine with me', I just sort myself out and have what I fancy." Each person had their own refrigerator and dry food storage cupboard in the kitchen. We saw people helped themselves to drinks and snacks throughout the day.

We saw records of involvement from other health and social care professionals such as a psychologist, a learning disability nurse, community nurses and a local authority care coordinator in order to meet people's general care needs. This showed that the service supported people to maintain good health and well-being and they had access to other services when they needed them.

Although the provider was not the landlord, staff had supported people to make the premises homely. An

extension had been built onto the property which the service had offered to one person as a self-contained flat. The person was able to live separately from the other tenants but had access to the communal areas of the house if they wished. We saw personalised photographs, ornaments and other knick-knacks on display around the house. People had pleasantly presented bedrooms with soft furnishings and décor which met with their own tastes. Staff supported people to carry out domestic chores which we saw taking place during the inspection.

Good

Is the service caring?

Our findings

We observed people were comfortable in the presence of staff. There was a friendly and homely atmosphere in the house. People told us, "I'm happy" and "They [the staff] are nice".

The staff we observed had a caring and kind approach towards the people they supported. They were respectful and professional at all times. During the inspection we spoke with staff about the type of service they felt they delivered. They made comments such as, "I think it's a good service", "People are very safe living here" and "We are like one big family." All of the staff we spoke with said they liked their job.

We observed many positive interactions between people and staff. The staff obviously knew people really well; we saw people enjoyed a good relationship with the staff who supported them. People had been involved and had contributed to the information recorded in their care plan. The 'Choosing my support team' section demonstrated people were involved in the recruitment of staff. People had contributed questions to ask potential new staff. People had also been involved in designing a recruitment advert, interviewing and checking references. A feedback booklet which was available in pictorial format was included to enable the person to feedback their opinion of the potential staff. Other information included, 'How was I involved' and 'What I did' which showed that people had answered questions about their health. Staff had asked people about their likes and dislikes, preferences, their past history, interests and hobbies in order to record personalised information.

We saw an apparent trust between people and their staff as they looked to the staff for reassurance during our conversations. We saw and heard staff offering people choice in all aspects of their support. For example, we heard one person discussing with their care worker about when and where they would like to go shopping. On another occasion, staff were encouraging a person to tidy their bedroom and offered choice about when this should be done. People were encouraged to select their own clothing and make decisions about daily activities. This meant people were receiving care which reflected their individuality and identity.

We reviewed a 'Service User Guide' and an up to date 'Statement of Purpose' which the provider had produced and shared with people who used the service. They were produced in varied formats such as pictorial and written to ensure everyone had an opportunity to understand the information. These documents contained information about the company's values and the expectations of service. They explained what the 'service user' can expect from the company and how the service would be delivered. They provided information on quality assurance, complaints and useful contacts. Some of the company's policies were also included for people's information such as staff conduct, health and safety and confidentiality.

Discussions with the registered manager revealed that people who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this.

Confidentiality was maintained during our inspection as staff spoke with us discreetly about sensitive issues. People's personal data and confidential records were stored securely in a designated office space.

We saw on the training matrix that staff had received training in equality and diversity, privacy and dignity. Staff told us that they encouraged people to be as independent as they could be and carry out tasks which they were able to do. One staff member said, "Staff always knock before entering people's rooms – no doors have locks on except the external doors so we have to be mindful of privacy", and "People can go to their rooms whenever they want and can move around the house freely, there are no restrictions, visitors can come any time, we have no issues with friends visiting although it's mainly just families." We saw staff closed bathroom doors when assisting people with personal care to protect their dignity. This showed the staff had an awareness of equality and diversity and they protected people's rights.

We asked the team leader about the use of formal advocacy services. They confirmed that nobody who currently used the service had a formal advocate involved in their care and support. They told us the service promoted the use of advocates when necessary and referred people to a local community service or the local authority. They said most people had family who usually acted on their behalf informally or staff would support them if it was appropriate. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Good

Is the service responsive?

Our findings

The people we spoke with were not able to fully communicate their views as to whether the service was responsive. We spoke with three people about their care and support and asked if they had any complaints. They told us they were happy with everything didn't have anything to complain about.

We spoke with the registered manager and staff about the processes in place to respond to people's needs. The registered manager told us the provider has a pre-assessment procedure and a referral assessment team which met up fortnightly to discuss new referrals and decide which of their services would be most appropriate for someone to live based on their compatibility with other tenants and the skill set of the staff team at each of the services.

A full assessment of people's needs was undertaken. This included all areas of daily living such as diet, mobility and sleep patterns. People's needs were explored and staff considered other external services which were also involved in a person's care. Other factors such as 'signs of relapse', 'crisis plans' and 'contingency plans' were included when creating care plans and risk assessments. Care plans were personalised and person-centred; there was full acknowledgement of respecting privacy and dignity when devising these plans. Self-care abilities, education, work, leisure and relationships were all included in the assessment.

Care plans contained thorough instructions for staff to follow in order to make the person's routine as smooth as possible and ensure their choices and needs were met. Care records also included a goal achievement record, which was used to monitor a person's progress towards a desired outcome. The staff had signed them to acknowledge they had read and understood what was required of them. They also signed to confirm they had supported one person who lacked capacity to understand their care plan.

The records we looked at were up to date and had been reviewed recently. An initial review was conducted six weeks after an admission to ensure people had settled in to the service and iron out any issues. Risk assessments were updated every six months and care plans annually unless changes occurred. Any change in a person's needs or support was recorded immediately and records were updated as necessary. Monthly meetings held between people and the staff were recorded in detail under the heading, 'My meetings'. Discussions had taken place to check that care plans were still appropriate, review actions from the previous month, staff support, health and safety issues, medicine support, tenancy issues, activities, finances and complaints.

Care records contained a 'hospital passport' document. If a person needed emergency care or treatment, this information could be removed from the care record and taken with the person. This ensured the person's care record did not leave the premises and provided effective communication between services. The hospital passport contained personal details, emergency contact information, health conditions and medical needs. It also included a section called 'Things that are really important to me' and 'Last wishes' to ensure people's wishes and preferences could be considered in an emergency situation or when a person was unable to communicate this for themselves.

The service had not received any formal complaints since its last inspection. The provider had a thorough complaints procedure in place which we reviewed in conjunction with the complaints policy. In the event of a complaint, information would be logged; concerns would be investigated and responded to in a timely manner. The registered manager told us any concerns or issues brought to her attention were dealt with immediately before they escalated to a complaint about the service. The registered manager also told us, "Verbal complaints are going to be improved; we are going to provide a written response to all complaints, so we have a record of them and can monitor them."

The service provided people with formal information about the complaints policy and procedure within their 'Service User Guide'. An easy-to-read 'Complaints leaflet' had been signed for in the records we reviewed. We also saw this was displayed on a noticeboard. Staff also asked for feedback during their monthly meetings with people. The team leader told us, "People are quite confident to approach us about anything."

People chose how they spent their time on a daily basis. On the day of inspection, one person had decided not to attend a scheduled art class. However, after a lie in and a shower, they changed their mind and staff supported them to attend at a later time. The three other people who used the service had no specific plans for the day, we saw they went with staff to the shops and engaged in conversation with us and the staff throughout the day. One person spent some time doing art and craft activities with staff in the lounge. We saw many pictures displayed on the walls which this person had drawn.

Three people had activity care plans which had been devised by staff based on their interests and hobbies; these were used as a guide by staff to encourage participation and social inclusion. People and their relatives (where appropriate) had been asked what they were interested in and the staff encouraged and facilitated these activities by conducting research into local amenities and accompanying people as necessary. We saw in care records that people had enjoyed a wide variety of meaningful activities and hobbies such as bike rides, disco's, bowling and bingo. The team leader told us, "We arrange karaoke nights in the house and have a take away night. (Person 1) likes a kebab on a Friday, whereas (Person 2) prefers a chippy." Other communal activities included day trips to see the Blackpool illuminations and a visit to Southport zoo. The team leader told us the staff were planning to accompany one person on a holiday soon.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. Our records showed she had been formally registered with the Care Quality Commission (CQC) since July 2015. The registered manager was aware of the responsibilities of her registration. The registered manager was present during the inspection and assisted us by liaising with people who used the service and staff. The registered manager was well established in her role and was knowledgeable about people's individual needs.

The staff we spoke with told us they enjoyed their job. Staff told us they felt the management team were supportive and wouldn't hesitate to approach the registered manager to report anything they were worried about. They told us they were confident issues would be dealt with appropriately and timely.

We observed a positive, open and transparent culture at the service. Good leadership was evident with certain tasks successfully delegated to the team leader. Staff understood their role and responsibilities. They were able to tell us what these were. Policies and procedures were reviewed annually and staff records confirmed that staff had been asked to re-read and sign a statement of understanding.

Staff attended team meetings on a quarterly basis. The last meeting held in August 2016 covered training, safeguarding, audits and health and safety issues. Staff had an opportunity to discuss the needs of each individual person and their progress towards desired outcomes. A regular 'Tenant' meeting was also routinely planned; however these meetings depended entirely on the preferences of each individual at the time of the meeting. Staff told us they scheduled the meetings in advance but sometimes people didn't want to be involved. The last meeting held in October 2016 did go ahead. People discussed upcoming activities such as Halloween, health and safety, domestic chores and good hand hygiene. This showed that the service empowered people to be actively involved in the service.

We reviewed incidents, accidents and safeguarding concerns and saw these had been fully investigated. The team leader and registered manager liaised with external professionals to resolve concerns about people's health and well-being. We saw in team meeting minutes that events and outcomes were discussed, best practice was shared and where improvements could be made, actions were put in place. The registered manager showed us her monthly report which she maintained for the provider's oversight. We saw operational activity was recorded such as accidents, incidents and safeguarding concerns and were collated across the provider's other services to enable them to identify themes and trends.

The registered manager conducted quarterly health and safety audits and quarterly reviews. This information was recorded and cascaded to the provider for monitoring purposes. The registered manager told us, "The service manager's workbook is a good tool for oversight." We saw the registered manager was completing this report in the absence of a service manager in order to maintain a record of monthly data. The purpose of the report was to ensure the registered manager had oversight of the service once a new service manager was in post. Action plans were created following these audits to ensure all staff were aware of their responsibilities with regards to the improvement and development of the service. We found the last three medicine audits had not been fully completed. The audits had not been signed by the person who

carried them out and a record of actions taken following the issues highlighted had not been documented. After the inspection, the registered manager provided us with an action plan which was in place to address the gaps identified in the service following the resignation of the previous service manager.

The provider's quality assurance team visited the service periodically to carry out an independent quality review of the service. This audit was based on CQC's model of inspection. At the last quality audit dated 2016, the service achieved 76% and was awarded an overall 'good' rating. Following this, the registered manager had submitted an action plan to the provider with timescales and the status of progress towards each action point. An easy-to-read leaflet about the provider's quality audit was shared with people who used the service to ensure they understood the purpose and the outcome of the audit.

The registered manager met regularly with her colleagues from the provider's other services in the region to share and discuss best practice from services with high scoring quality audits. The registered manager told us they discussed learning from errors in other services and looked at themes and improvements from safeguarding alerts and other incidents. Overall we found robust audit procedures in place which both the registered manager and the provider were fully involved in to monitor the quality and safety of the care people received from the service.

People and staff were empowered to be involved with the service. Both were encouraged to complete satisfaction surveys. These surveys were carried out by an independent organisation that collated the results and presented them to the provider. The organisation also produced an easy-to-read version for the provider to share with people as necessary.

The provider produced a quarterly magazine called 'Lifeline'. They also maintained a Facebook page and Twitter account. This enabled people and staff to 'follow' news stories and receive live notifications when information was being shared. People and staff had been asked to share good news stories and were interviewed by the magazine editor.

The provider had arranged a staff engagement day. A representative from the provider's human resources (HR) function facilitated a workshop called 'My staff, my day'. Staff were invited to speak in confidence about their job and discuss any issues they faced in the service in which they worked. They shared ideas with staff from other services and made contacts through networking.