Augusta Care Limited

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Inspection report

Toll Bar House
Shrewsbury Avenue
Peterborough
Cambridgeshire
PE2 7BX

Tel: 01733233725

Date of inspection visit:
12 March 2018
16 March 2018

Date of publication:
10 April 2018

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

Augusta Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats and supported living houses; it provides a service to older adults and younger adults.

This service provides personal care and support to people living in 42 supported living settings so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using Augusta Care Limited receives the regulated activity; CQC inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

This announced inspection took place on 12 and 16 March 2018. This was the first inspection of this service since their CQC registration changed in 30 September 2016. There were 73 people, who live with a learning disability and who may also have mental and physical health needs, receiving the regulated activity of personal care at the time of this inspection.

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

Staff had an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff knew how and where to report any suspicions of harm and poor care practice.

People were assisted to take their medication as prescribed.

Processes were in place and followed by staff members to make sure that infection prevention and control was promoted and the risk of cross contamination was reduced as far as possible when supporting people.

Staff assisted people in a caring, patient and respectful way. People's dignity and privacy was promoted and maintained by the staff members supporting them.

People, their relatives, and advocates were given the opportunity where appropriate to be involved in the setting up and review of people's individual support and care plans. People were supported by staff to have enough to eat and drink.

People were assisted to access a range of external health care professionals and were supported by staff to maintain their health and well-being. Staff and external health care professionals, would, when required, support people at the end of their life, to have a comfortable and as dignified a death as possible.

People had individualised care and support plans in situ which documented their needs. These plans informed staff on how a person would like their care and support to be given, and how it was to be given in line with external health and social care professional guidance. However, some people's care, support plans and risk assessments lacked detailed information as guidance for staff on how to mitigate people's known risks.

There were enough staff to meet people's individual care and support needs. Individual risks to people were identified and monitored by staff. Plans were put into place as guidance to staff to minimise people's risks as far as possible to allow them to live as safe and independent a life as practicable.

Accident and incidents that occurred at the service were recorded. Learning from these incidents were communicated to staff and reviewed as part of the on-going quality monitoring of the service. This was to reduce the risk of recurrence and drive improvements forward.

There was a recruitment process in place and staff were only employed within the service after all essential checks had been suitably completed. Staff were trained to be able to provide care which met people's individual needs. The standard of staff members' work performance was reviewed through competency checks, supervisions and appraisals.

Compliments about the care and support provided had been received. Complaints received were investigated and resolved to the complainant's satisfaction where possible.

The registered manager used innovative ways to involve people in the running of the service. This included a service user forum to discuss ideas and listen to external guest speakers and to help with the monitoring of the service.

The registered manager sought feedback about the quality of the service provided from people, relatives, staff and other stakeholders. There was an on-going quality monitoring process in place to identify areas of improvement needed within the service. An overview of this information was also shared with the organisations board of directors by the registered manager to make sure organisational oversight was in place.

The provider's records showed that some incidents that the provider was legally obliged to notify the CQC of had not been submitted in a timely manner.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Lessons were learnt and action taken as a result of any accidents and incidents that occurred were documented and reviewed to reduce the risk of recurrence.

Risks to people were assessed and monitored to make sure that people remained safe.

There was an adequate number of staff to meet people's assessed needs and recruitment checks were in place to ensure that staff were of a good character.

Processes were in place to ensure that people's medication was managed safely.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed and staff supported people in line with legislation.

Staff received training, supervisions, and appraisals to support the needs of people appropriately.

Staff worked with other organisations to deliver effective care and support.

People were assisted, when needed, to have access to external healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect when being supported by staff.

People were involved in making decisions about their care and support needs.

Staff promoted and maintained people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Complaints received by the service were investigated.

People's needs were assessed and staff used this information to deliver personalised care that met people's needs.

People's end-of-life wishes were not always recorded as guidance for staff.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

Monitoring was in place to oversee the quality of the service provided and make any necessary improvements.

People were encouraged to be involved in the running of the service and give feedback on the quality of care provided.

Augusta Care Limited

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.

The inspection site visit activity started on 12 March 2018 and ended on 16 March 2018 and was announced. We gave the provider 48 hours' notice of the inspection. This was so that we could be sure that staff would be available during this inspection. The inspection was carried out by one inspector. We visited the office location on 12 and 16 March to see the registered manager and staff, to review care records and records in relation to the management of the service. We also spoke with people using the service.

Before the inspection we looked at all the information we held about the service. This included the provider information return (PIR) which was submitted to the Care Quality Commission on 8 December 2017. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also looked at information we held about the service and the provider. Before the inspection we asked for information from representatives of a local authority contracts monitoring team, hospital psychiatry team, speech and language therapists, safeguarding team; and Health watch. We received information from a local fire safety officer. We also sent out questionnaires to people, relatives of people who used this service and health and social care professionals to feedback on the quality of care provided. This helped us with planning this inspection.

During the inspection we spoke with six people who used the service. We also spoke with the registered manager; the quality officer; a care-coordinator; a senior support worker and six support workers.

We looked at four people's care records and records in relation to the management of the service; accident and incident records; management of staff; and the management of people's medicines. We also looked at the provider's statement of purpose; service user guide; surveys; meeting minutes; compliments and complaints received; staff training records; and three staff recruitment files.

Good

Is the service safe?

Our findings

People told us that they felt reassured and safe using the service. This was because people's risks had been identified and the assistance given to them by staff to manage these risks. One person told us, "I feel safe when [staff] are around me in the kitchen so I don't burn myself." Another person said, "[I get] support 24 hours a day, I feel safe."

Staff received training on how to safeguard people from poor care and avoidable harm. They said they would report concerns in line with their training and they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff explained how they would report poor care and suspicions of harm both internally to the registered manager and to external agencies. A staff member told us, "I would report concerns to the [registered] manager but I know that I can also report concerns outside of the agency. I would report to the CQC." Information and guidance about how to report concerns were available for staff to refer to if needed. A person confirmed to us that, "Staff are kind, they don't raise their voices, speak nicely." This showed that there was a process in place to reduce the risk of poor care practice.

People's support and care plans were stored securely within the office and stored in people's own homes. Risks to people had been identified and assessed when they first came to use the service and as staff got to know them and their individual requirements. These risks included being at risk of self-neglect, self-harm or having suicidal thoughts. These records provided prompts and information for staff on how to assist peoples safely and reduce the risk of harm where possible, whilst promoting people's independence. However, we did note that some information including the Speech and Language Therapist guidance on exactly how small food should be cut into to reduce the risk of choking; and the maximum temperature a person's bath and shower water should be to reduce the risk of scalding, was not always included as information for staff in the support plans. Staff spoken with demonstrated to us that they knew how small food should be cut into and told us they always checked the water temperature first, before supporting a person with their personal care. However, these safety checks undertaken by staff were not always documented. The registered manager told us that they would make the necessary improvements to peoples care, support plans and risk assessments.

People told us that they made their own decisions about their care and support and that their choices were respected and listened to by staff. Records showed that people, where possible, had signed to say they had agreed with their plans of care, support required and risk taking. This showed that people were aware and involved in decisions around their care.

People had personal emergency evacuation risk assessments in place to assist them to evacuate their homes safely in the event of an emergency such as a fire. This showed us that there was a protocol in place in the event of an emergency.

Technology was used to support people to receive safe care and support when required. A person told us that there was a, "Button I can press," to summon staff when needed in an emergency. This showed us that

technology was used to support people where needed.

Staff told us they were trained in Non- Abusive Psychological and Physical Intervention (NAPPI), which supports staff to manage people's behaviour when they were becoming a risk to themselves and/or others. Staff explained that they used known distractions to help decrease a person's anxiety. This was confirmed in the records we looked at. A staff member said, "Distractions include giving [a person] space. Every person has their own assessment regarding their behaviours [for staff to refer to]." This showed us that when people's behaviour challenged, trained staff used a known technique to manage behaviours that could be challenging.

Before the inspection the Care Quality Commission received some concerns that said some people were not receiving the one-to-one support they were funded for and that there was a lack of staff at weekends. People we spoke with told us that they had a consistent group of staff supporting them, which was their preference. This was because they got to know staff and staff got to know them and how they liked to be supported. People received a rota in advance that would tell them which staff would be supporting them on what day and time. A staff member said, "We try to use a group of [staff] consistently. We send rotas to people; any changes to this, people are updated." Based on people's dependency needs and their funding we were told that people, where needed, were supported by staff on a one-to-one basis. People said that staff supported them with their personal care, any activities they took part in, attending health care appointments and helping them with daily living tasks including cleaning and shopping. This told us that there was sufficient numbers of suitably skilled staff to look after people who provided them with a continuity of care and support.

Checks were carried out on new staff members to confirm that they were appropriate to work with people and were of good character. Staff told us that these checks were in place before they could start work at the service. This showed us that there was a process in place to make sure that staff were deemed satisfactory and suitable to work with the people they supported.

People using the service were either able to manage their prescribed medications themselves, or had been assessed as either needing a prompt (reminder) by staff as to when to take their medication, or staff administered people's medication for them. Staff knew when to support a person with their 'as required' medication for pain relief or medication to help manage behaviours that could challenge. However, although staff knew the people they supported well, we saw some records about this type of support did not always sign-post staff to the known distractions they should use before resorting to medication. There was also no information as to when staff should flag any concerns, such as an increased use of 'as required' medication to the registered manager. The registered manager told us that they would make sure that this was clearly documented within people's care records as information for staff going forward.

People spoken with had no concerns around how staff helped them with their medication. One person confirmed to us that, "I'm independent, I self-medicate." Another person told us, "Every morning staff help me with my medication. Staff give [my] medication promptly."

Staff told us that they had received training before they could administer people's medication and that their competency to do this was checked by a more senior staff member. Records of people's medication administration were checked, as part of the services governance systems. These checks were to ensure that people's medication administration records were accurate. Any staff errors in recording or administration of medication, including any gaps in records, or reasons why a person refused or did not take their medication were addressed by the management team with the staff member involved. This demonstrated to us that there were processes in place to make sure that people's medication was managed safely.

Staff were aware of their role in preventing the spread of infection and cross contamination, when supporting a person with their personal care and when helping people with their food. A member of staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. Staff received training on food hygiene and how to prevent or manage any potential infections. This showed us that procedures were in place to help reduce the risk of infection and cross contamination.

Accident and incidents that occurred at the service were recorded as 'learning logs' and reviewed as part of the services governance system. A staff member confirmed to us that, "Team meetings happen and learning from incidents or audits are communicated to staff." Another staff member said, "[Staff] get email updates as a result of learning [from incidents]." This confirmed to us that lessons were reviewed as part of the governance systems and any improvements required communicated to staff to reduce the risk of recurrence.

Good

Is the service effective?

Our findings

External health and social care professionals worked with the registered manager and staff to help them support and promote people's well-being in line with good practice guidance. This was reflected within people's care records. One external health care professional told us that when they had a concern about some staff following their guidance, they communicated this with the registered manager who followed these concerns up with the staff involved. Actions taken included booking staff onto further training with immediate effect. Another external health care professional told us that staff were beginning to implement the recommendations that they had been given and that the work was currently ongoing. They went on to say that they felt some improvements were needed to communicate good practice guidance consistently throughout the service. This showed us that staff worked with external health and social care professionals to try to make sure people's needs were met in line with up-to-date guidance and good practice. However, some work was still needed to make sure that best practice guidance was communicated and implemented consistently across the service.

People were assessed for and used equipment to promote their mobility needs. Support given by staff gave people reassurance when they were using this equipment. One person confirmed to us that, "Staff put [the] lap belt on [when using wheelchair] so I don't fall out."

Before the inspection the Care Quality Commission received some concerns that said staff did not always receive adequate training. We found that staff completed training to ensure that they had the right skills, experience and knowledge to provide the individual care and support people needed. Training included, safeguarding adults; moving and handling; learning disability awareness; autism awareness; effective communication; medication administration; first aid; and care vales (including equality and diversity and dignity of care). Training was also undertaken on the Mental Capacity Act 2005 (MCA); health and fire safety; fluids nutrition and food hygiene; and infection prevention and control. This showed us that were processes in place to make sure that staff were given training to help them provide effective care and support.

Staff told us that they were supported through observation / competency checks, supervisions and appraisals. They said that these were carried out by senior staff members and that these were a 'two-way' (joint) conversation. This, they said helped them feel supported and listened to. When new to the service staff had an induction period, where they completed the 'care certificate.' This is a nationally recognised health and social care induction training programme. This induction included training and shadowing a more experienced member of staff. A staff member told us, "[I was] super-nummery [not on rota] and worked shadow shifts to get to know the person [I would support] and to make sure that they were happy." This was in place until staff were deemed competent and confident by the registered manager to provide care.

People could choose to eat out or prepare and make their own meals and drinks, by themselves or with some assistance from staff. One person told us how they, "Made fish cakes and helped peel potatoes." Another person said, "Staff give me choices, like fruit. I have had two fruits, a pear and an apple before coming out [today]." Staff supported people with their specialist diets due to specific health conditions that

may have put a person at a higher risk of choking, or a person being at risk of being underweight or overweight." A staff member told us that when supporting a person at risk of choking, "[You] follow SALT (Speech and Language Therapists) guidelines in the care record. Crusts are cut off sandwiches and cut food into 20p pieces size. You also use extra spread and sauces so food is not dry." Another staff member said, "I help [named person] with food shopping, they are currently at [named weight loss programme], so we are looking at healthier meal and ingredient options." The person they supported proudly told us how much weight they had lost. They said, "I now go for low fat meat and eat lot more fruit which I enjoy eating." This showed us that staff supported and encouraged people with their food and drink requirements.

The service worked and communicated with external organisations to make sure that staff could meet people's needs and that a good service was provided. For example, we saw recorded evidence of staff working in conjunction with the person's local authority pre assessment review record of their care and support needs; or with representatives from the local mental health crisis team; speech and language therapists, hospital psychiatry team and local authority safeguarding team. People's care records held the contact details for external health and social care professionals involved with each person as a prompt for staff should they need to contact them. Records looked at evidenced that external health and social care professionals were contacted, following any concerns raised about a persons' well-being or incidents that may have occurred. An external health professional said that representatives from the service attended external meetings at short notice and engage and communicate well. The also said that the registered manager at the service made changes to the care provided in response to external professionals guidance. This showed us that staff were aware of people's changing needs and risks and when they needed to, involved and worked with other agencies and services to support the person.

People told us that they were able to attend external health care appointments independently or with support from staff. One person told us, "[Staff] support me to go to appointments when I book one." Another person said, "Staff support [me with] GP appointments." This demonstrated to us that people's health and well-being needs were monitored and acted upon by staff.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff had undertaken training in the MCA and were able to demonstrate a good understanding of why it was important to encourage people to make their own choices. People spoken with confirmed to us that staff listened to and respected their choices. Staff supported people with their decision making using prompts or different communication tools for people with limited or no speech. These communication tools included picture boards, visual prompts or other communications tools as set out in a person's communication passport. Documented evidence showed that MCA day-to-day decision forms were in place and people's mental capacity was assessed to determine whether they could make day-to-day decisions for themselves. Applications had been made with the appropriate authority regarding some people who were under constant supervision by members of staff and lacked the mental capacity to retain the information and consent. These applications were still with the supervisory body and decisions surrounding these applications were pending. This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

People had very positive opinions about the care and support provided by staff. They told us that although staff assisted them, staff members always continued to encourage people and uphold their independence. One person said, "I am happy." Another person told us that, "[Named staff] supports me, I am happy with the support." A third person said, "[I'm] happy with the support. [Named staff] makes me happy, [they] help me cook and we have a laugh when cooking." Records informed and guided staff on what people were able to do for themselves and when staff were to offer people additional support. This meant that staff had knowledge on how to promote, support and maintain people's independence.

People told us they were encouraged to express their views, were listened to and were involved in decisions about their care and support where appropriate. When speaking to people and their support staff, we saw that people were comfortable and confident to do so. Staff said that working and supporting the same people meant that a trust was built up and we observed a jovial but respectful interaction between both parties. A person told us, "I visit the [services] office once a week to drop paperwork in and I get to speak to the [registered] manager and staff." Another person said, "Support is very good…I am able to make [my own] choices." A third person told us that, "Managers ask for feedback."

A service user forum had been set up for people using the service to attend. Feedback was asked from people on how the service was run and how people would like to be involved. A person confirmed to us that at these meetings, "You discuss ideas and things. [The registered] manager listens to what suggestions have been made." These included requests to visit a local fair and to go on holiday. A person then went on to tell us how they had come up with the idea of taking part in a sponsored event and that staff had helped with this. The person was able to tell us with the support of staff the money they had raised for this chosen good cause. The interactions with the staff and the registered manager showed us that this achievement had given the person using the service a great sense of pride.

Guest speakers were also invited to attend the service user forum. Records showed that a recent guest speaker had spoken to people about the local 'safe place scheme' initiative. This scheme was to support and promote people with a learning disability or on the autistic spectrum to know where to go if they felt 'unsafe' whilst out and about in the community.

People were also invited to share stories of their recent achievements; this included a person who attended an entertainment venue for the first time. The person was then asked to write and share their story documenting their trip and their experience in the newsletter that was shared with people who used the service. This showed us that staff strove to involve people to give their feedback, feel involved, feel valued and make choices about their care and well-being.

Advocates were used to support people who required additional assistance in making decisions about their care, support needs and treatment. Advocates are people who are independent of the service and support people to make and communicate their views and wishes.

Staff had knowledge of and respected the people they were providing care and support for. They were able to show us that they knew about people's backgrounds, and any preferences they had. Wherever possible, people were supported by staff that understood and valued their religious or cultural beliefs. A staff member said," I can suggest where a new staff member should be assigned to a person or not. We have some people that like female [staff] and this is supported. For other people, there are religious reasons [why] they only want male [staff]."

People's privacy and dignity was promoted and maintained by staff. People told us that when a staff member wanted to go into a person's room, they announced themselves before going in. A person told us, "[Staff] respect my privacy. They stand outside the door when I am showering." Another person said, "When staff come in on shift, they knock on the door [before entering]."This showed us that staff respected and promoted people's privacy and dignity.

Good

Is the service responsive?

Our findings

Care and support plans and risk assessments recorded people's daily living needs, and care and support requirements at each shift. These had been developed in conjunction with the person, their relatives, legal representative and advocates, and in line with the local authority pre assessment review, prior to them using the service. These records were in place to give guidance to staff on how they could meet the person's individual care and support requirements. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current assessed requirements. An external health care professional told us that the care provided by staff was person centred and that staff were well intentioned. This showed us that staff were able to get to know the people they were supporting.

People, were supported by staff to maintain their links with the local community, to attend further education classes, and to follow their interests and hobbies. We saw that the staff at services office proudly displayed the results of people's art and craft sessions. Posters were also displayed inviting and encouraging people to take part in different events being held in the near future. One person told us, "Staff support my activities. I do archery, swimming, art and crafts and [named health loss programme]." They then proudly showed the most recent crafts they had made during an art session. Which they said they, "Enjoyed." Another person said, "Staff help me go to activities, I went to a funfair and I enjoy going to a nightclub." This demonstrated to us that people were supported to maintain their interests, find new interests and maintain their links with the wider community.

We saw that the service received compliments and thank you cards from people who used the service, their relatives and external health care providers. Compliments were used to identify and communicate to staff what had worked well.

Records documented that the service had received complaints. Complaints had been investigated and there had been efforts to resolve the complaint to the complainants' satisfaction wherever possible. People told us that they would raise any concerns they had with the staff that supported them or the registered manager. One person confirmed to us that staff, "Listen."

It had been identified during a local authority contracts monitoring visit in July 2017 that there were insufficient detail recorded around complaints. The registered manager told us that this was an area requiring improvement and showed us the new form to be used to document this information in more detail. This would help make sure that evidence of any investigations could be evidenced including any learning as a result of the complaint investigation and the record of the complaints outcome. This, they told us, would then be used to look for any patterns and trends in complaints as part of the services governance system.

The registered manager told us staff were not trained in end-of-life care and that people's end-of-life wishes were not always documented. However, the registered manager had asked their organisations trainer to attend a course on this subject and to then start rolling out this training to staff members. The registered manager said that to support people approaching the end of their life they would work with the person and

their family to make sure that they met their wishes, including their preferred place of death. They also told us that they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. This was to enable staff to support people to have the most comfortable, dignified, and pain-free a death as possible.

Care records did not always document people's end of life wishes, including any wish to be or not be resuscitated; or any end-of-life cultural and religious wishes; funeral arrangements; and preferences. This created a risk that people's end-of-life wishes may not always be met.

Good

Is the service well-led?

Our findings

A registered manager was in place, who was supported by three managers, senior support staff, support staff, and ancillary staff. 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.

Records showed notifications had been received from the registered manager that the registered manager was legally obliged to notify us of. However, we became aware that there had also been some safeguarding incidents that had been referred to the local authority safeguarding team that the CQC had not been notified of in a timely manner. We discussed this with the registered manager during this inspection and they confirmed to us that improvements will be made going forward.

Staff told us that there was a clear expectation, by the registered manager, for them to deliver high quality care and support and that the registered manager and managers were approachable. A person confirmed to us, "Staff look after me well." A staff member said, "The registered manager is very approachable. You can speak to the managers. There is always someone you can talk to…I feel supported." Another staff member told us, "If you ring on-call it is always answered."

During the inspection the registered manager told us that they were aware of the CQC guidance of 'Registering the Right Support' and that they ensured the key principles underpinned the service's values and care provided. This is the CQC policy on the registration and variations to registration for providers supporting people with a learning disability. However, the registered manager confirmed that they were not currently signed up for 'The Driving Quality Code.' This code was developed following the Winterbourne review that identified abuse of people with learning disabilities. The government and many other organisations that support people with learning disabilities are taking action to make sure that this never happens again. The registered manager told us that they would sign up for 'The Driving Quality Code' and familiarise themselves with this guidance.

The registered manager had come up with an innovative way of involving people in the running of the service. 'Champions' had been advertised for and people were asked to volunteer to become a 'champion' within a specific area. This included, but was not limited to; a 'dignity' champion, a 'medication' champion and 'safeguarding' champion. To become a champion you would receive training in your specialism and would attend and help deliver staff training in these subjects. This, one person told us had given them a real sense of pride that they had a training certificate and this had helped with their confidence. One person said, "I've done medication training. I go round services [supported living locations within the service] and help staff to do it [medication] properly." They then went on to tell us that whilst attending staff training, they could tell staff their experiences of what it felt like to be supported with their medication. Another person told us, "I am a dignity champion. I will visit people's houses and see what is good [dignity practice] and what needs improvement." These demonstrated to us that people's views and experiences were gathered and acted upon to shape and improve the service provided.

Evidence of learning as a result of the investigations into accidents, incidents was available and was used as an organisational oversight tool, to learn, improve and sustain the quality of the service provided.

Questionnaires were sent out for people, their friends and relatives' and staff by the registered manager to ask them to engage with the service and feedback their views. Records showed that responses were positive. Any areas for improvement were noted and where possible they were being acted upon. For example, staff were reminded that they must share with the person they are supporting what they had documented in the person's care record.

The registered manager told us and records showed how they worked in partnership with and shared information with key organisations to provide good care to people at the service. This included working together with people's social workers; speech and language therapists, local authority contracts monitoring representatives and safeguarding teams and the hospital psychiatry team. Following recent inspections on some of the supported living locations by the fire service, deficiencies had been found. Records showed that the registered manager was working in conjunction with the fire safety officer and the external property management company to make the necessary improvements. This demonstrated to us that the registered manager shared appropriate information with other relevant agencies where appropriate to benefit the people using the service.