United Response

Wigan DCA

Inspection report

2nd Floor, Lloyd House
Orford Court, Greenfold Way
Leigh
Lancashire
WN7 3XJ

Tel: 01942263500
Website: www.unitedresponse.org.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 22 and 23 March and was announced. We gave the provider 24 hours' notice of our inspection to ensure there would be someone at the office we could speak with and in order to help us plan the inspection. We last inspected Wigan DCA on 22 January 2014 when we found the service to be meeting all standards inspected.

Wigan DCA is a branch of United Response, which is a national charity. The service provides care and support to people living with learning disabilities, physical disabilities, mental health needs and people on the autistic spectrum. The service provides support to people living in shared or single occupancy accommodation as part of a supported living service. Wigan DCA also provides domiciliary or 'outreach' support to people living in their own home. We did not inspect this aspect of service provision, as this part of the service was not providing any regulated activities at the time of our inspection. The supported living service was providing support to people living at 18 addresses across the Salford, Stockport and Wigan areas. Wigan DCA had taken over the running of the Stockport service in December 2015.

At this inspection we found the service was meeting the requirements of the regulations. We have made one recommendation for the provider to review guidance in relation to the safe management of medicines.

There was a registered manager in post at the time of our inspection. 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.

We found medicines were being kept safely and had been administered as prescribed. However, at one house we found the administration record did not list the correct medicines on it. Staff had not identified that the administration record was incorrect and had signed to show medicines had been administered when they had not. This meant an accurate record of the medicines given had not been kept.

People told us they felt safe being supported by staff working in their home. We saw risk assessments had been completed and staff were aware of the control measures identified in risk assessments and support plans to reduce risk to people. However, risk assessments were not always clearly laid out and sometimes contained limited information. The registered manager told us they would conduct a review of all risk assessments.

At one house we found hazardous substances including ant powder and bleach were being kept in an unlocked cupboard and there had been no risk assessment in relation to these items. We felt there had not been a risk to the individuals living at that house; however this was also against the services policy on control of substances hazardous to health (COSHH). The registered manager confirmed the items had been removed after we made them aware of this concern.

Staff were positive about supporting people's independence and had a person-centred approach. Staff at one house told us about how they had supported people to become more independent in making their own drinks through consistency of approach, prompting and using hand-on-hand techniques. Staff had an understanding of supporting positive, considered risk taking. For example they talked about supporting people to gain independence to travel alone.

Care plans were person-centred and contained information on people's preferences and interests. Current goals had been set for people and staff were able to tell us about some of the goals they had recently supported people to achieve. There was evidence that consideration had been given to supporting people to access employment and education opportunities if this is what they wished to do.

People were supported by consistent teams of the same staff members. Staff told us agency staff were not used by the service. People told us they got on well with the members of staff who provided support to them. They told us staff respected their privacy and dignity.

We saw that staff communicated clearly and respectfully with people. We observed many positive interactions between staff and the people they were supporting. Care plans contained a good level of detail to support staff to be able to communicate effectively with people. There was some accessible format information available for people such as pictorial versions of the safeguarding and complaints policies. One person's care file also had a pictorial short version of their care plan, which would help involve them in their care planning.

Staff at all but one house we visited told us they had received regular supervision. The registered manager told us they would address the issue of any missed supervisions with the responsible manager. Staff said they felt supported and able to approach their manager with any concerns they might have.

Staff received a range of training, including training in safeguarding and the mental capacity act. Some staff had received additional training, such as training in autism, epilepsy and communication, which would help them provide effective support to people using the service. We noted some gaps in the training matrix, such as with the completion of training in positive behaviour support. However, all staff we spoke with told us they felt they had received sufficient training and felt competent in their roles. The registered manager told us the training matrix needed updating due to the responsible member of staff being absent at that time.

Relatives we spoke with told us they felt the service were effective at meeting their family member's needs. One relative also told us their family member's needs had changed significantly in the time they were being supported by the service. They said the service had responded effectively to and 'embraced' these changes.

We saw people in the houses we visited were able to help themselves to food and drink and were involved in shopping and preparing meals where they were able to do so. Information about people's support needs and preferences in relation to food and drink were recorded in their care plans. We saw that support was provided in accordance with the guidance set out in risk assessments and guidance received from health professionals.

We saw a range of healthcare professionals had been involved in people's support. Health action plans had been completed, which included advice for staff on how best to support people to meet their health needs. One person's file we looked at contained an out of date appointment checklist. Staff told us this was due to the care file moving over to a new format. Another person required staff to check the condition of their skin. Although staff were aware of this requirement, no record was made. The registered manager told us this had been implemented shortly after our inspection.

Staff told us they would be made aware of any new guidance received through handovers and the communication book. The registered manager told us new procedures had also been introduced whereby team leaders would check staff competence and understanding in relation to any new guidance received.

Regular audits of the quality and safety of all houses was undertaken by service managers. This was in addition to regular checks made at the home in relation to health and safety, medicines and finances for example. At one house we found a three week gap in the weekly medicines check. However, all other checks we viewed had been completed on a consistent basis.

The registered manager took actions based on the feedback we provided on the inspection and updated us as to the progress made against any areas of concern or good practice we highlighted. Staff told us the provider was responsive for requests for resources to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

We found one person's medication administration records had not been accurately completed. Although this person had received their medicines as prescribed, the records did not indicate this.

We found hazardous products were not being kept safely and in accordance with the services guidelines at one house. Prompt action was taken to resolve this issue after we made the registered manager aware.

Staff were aware of people's support needs and the measures required to reduce any potential risks to them as outlined in their risk assessments and support plans.

Is the service effective?

Good

The service was effective.

People's care plans contained a good level of detail about supporting people to make decisions. This would help ensure staff were consistently able to support people to make their own decisions whenever possible.

People's care plans contained information about their dietary requirements, preferences and the support they needed to eat and drink. We saw staff supported people in accordance with guidelines from health professionals.

Staff told us they received a comprehensive induction when they started working for the service. They told us they had regular contact and support from their manager. We saw staff member's competency had been checked before they started lone working.

Is the service caring?

Good

The service was caring.

There were 'core teams' of staff who worked consistently with the same people. People told us they liked the staff who worked

in their homes. Our observations of staff interaction and discussions with staff indicated staff knew the people they were working with well.

There was a person-centred ethos, and staff had a positive approach to supporting people's independence. Staff talked to us about supporting people to develop skills such as making their own drinks.

People told us that staff respected their privacy. Staff told us it was important to allow people space when they wanted it.

Is the service responsive?

Good

The service was response.

People took place in activities supported both within and outside the home. Consideration had been given to supporting people to access employment, voluntary and education opportunities where this is what they wanted to do.

Relatives told us they felt the service was responsive to their family member's needs. One person told us about how their relative's needs had changed dramatically over time, and they told us the service had embraced these changes in a caring and sensitive way.

There were goals set in people's care plans that staff were aware of. Staff were able to tell us about some of the goals people had recently achieved, which included goals to go on holiday and to go to a music concert.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt supported by their managers and able to approach them to raise any concerns. Staff told us they enjoyed their jobs.

Processes were in place to monitor the safety and quality of the service. Regular audits were carried out by service managers in addition to daily and weekly checks carried out at each house.

The registered manager ensured prompt actions were taken to address any concerns or other points of feedback we provided from the inspection.

Wigan DCA

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 22 and 23 March and was announced. The provider was given 24 hours' notice of our inspection. This was because the location provides domiciliary and supported living services and we needed to be sure someone would be in to facilitate the inspection. This also allowed us to plan to visit people who were using the service. The inspection team consisted of two adult social care inspectors.

Prior to the inspection we reviewed information we held about the service. This included the last inspection report and the statutory notifications we had received from the service. Statutory notifications are notifications of significant events, such as safeguarding incidents and serious injuries that the service are required to send us. We also reviewed the Provider Information Return (PIR) that the provider had completed in advance of the inspection. This 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. We also sought feedback from the quality assurance team at Wigan Council, Wigan Safeguarding, Wigan Healthwatch and commissioners of the service. Healthwatch is the national consumer champion for health and social care.

During the inspection we visited people being supported by Wigan DCA living in two houses in Wigan and two houses in Salford. We spoke with five people being supported by the service and observed interactions between staff and people throughout our visits. We spoke with two relatives of people using the service during our inspection and an additional two relatives by phone shortly after the inspection.

We spoke with 11 members of staff. This included the registered manager, two service managers, four support workers and a team leader during the inspection. Shortly after the inspection we spoke with a second team leader and two further support workers by phone.

We visited the main office of Wigan DCA as well as a satellite office in Stockport where we reviewed records relating to the running of the service, such as quality audits and five staff personnel files. We reviewed seven

care files and eight medication administration records (MARs).

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we were made aware that the coroner had sent a regulation 28 'report to prevent future deaths' to the provider. Coroners send these reports to relevant persons or organisations where they believe actions are required to prevent future deaths. This report was in relation to a choking incident that had occurred at the service and resulted in the person's death. The concerns raised by the Coroner included, staff not holding keys, which meant people requiring continuous observation may not receive this if staff had to answer the door; staff understanding of requirements set out in risk assessments; and the training and procedures in place to ensure risks identified in health action plans and management guidelines were adequately addressed. We received a copy of the providers' response to this report that detailed how they intended to address the Coroner's concerns. We discussed this with the registered manager and considered the actions taken so far during our inspection. Our findings in relation to this are set out within the remainder of the 'Safe' section of this report.

The registered manager told us they had fitted a key-safe to one of the houses to ensure staff were able to enter the property when required without staff having to break away from providing support. We checked and saw the key safe had been installed. They told us they were in the process of reviewing procedures at other houses and were considering potential risks and balancing these against the aims of supporting people's independence and privacy. The registered manager told us rotas had been revised as a result of the incident to help avoid shift handovers occurring at times that might place people at risk, though it was acknowledged that the times that people ate for example, could vary from day to day. Staff we spoke with confirmed that shift handovers did not occur at times when people might require additional support such as meal times.

We saw there were risk assessments in place in relation to risks posed to and by people being supported. Risk assessments were not always set out clearly in a way that would allow staff to easily identify the risks and steps they needed to take to reduce any potential risks. However, staff we spoke with were aware of the risks and measures to reduce these as identified in their risk assessments, support plans and health action plans. For instance, one member of staff was able to detail the support a person required in relation to pressure care, eating and drinking and moving and handling and we found the information they gave was consistent with the care plan and assessments. The registered manager told us they were undertaking a review of all risk assessments to ensure they were adequate and presented clearly.

One moving and handling risk assessment we looked at contained limited details about procedures staff should follow when using a hoist. We saw moving and handling training had been arranged for the staff team supporting the person this risk assessment related to, and the registered manager informed us they had arranged for a re-assessment to be carried out. This would help ensure staff were aware of and following correct procedures and would reduce any potential risk.

We saw evidence of bespoke training having been provided to staff in order to meet individual's specific support needs. Staff told us if there had been any changes to a risk assessment or if new guidance had been received as the result of a health or social care assessment that this would be recorded in communication

books and information would be provided to them during shift hand-overs. The registered manager also told us new procedures had been introduced whereby all new health care assessments would be placed on the notice-board in the staff rooms and the team manager's would be required to check staff understanding and competence in relation to any new assessments received.

Staff we spoke with told us they felt there were adequate numbers of staff on duty to provide the support people required. We discussed with team leaders and the registered manager how they would respond if people's needs changed and the level of support required changed. Staff told us additional support would be provided as required and the local authority would be asked to review the level of support the person was funded for. The registered manager gave us examples of instances where they had negotiated extra support hours to ensure people's needs were being met effectively. Staff told us shifts were always covered and that they would be given the opportunity to review care plans and risk assessments before working with a person they hadn't supported before. Staff said they would usually shadow shifts before working with a person they hadn't supported before. However, one staff member said there could be occasions when there wasn't another member of staff available whom had worked with that person before and they would be required to provide cover. They told us they didn't always feel comfortable doing this and said they thought a 'floating' member of staff could be a possible solution.

We saw that medicines were kept safely in locked storage in the homes we visited. Records showed that staff member's competence to administer medicines following safe procedures had been assessed by their manager. We reviewed records of medicines administration and in most instances found records were complete and correctly filled out.

However, at one house we visited we found the medication administration record (MAR) did not list all the medicines that person was being administered. The staff member had not noticed this and had signed the records indicating that this person had received other medicines that had not in fact been administered. We checked stocks of the medicines for this person, which indicated they had received their medicines as prescribed. We raised this issue with the registered manager who told us the member of staff would be re-trained in medicines administration and that they would review how medicines were being supplied to reduce the risk of any similar error occurring.

We recommend the provider reviews national guidance on the safe management of medicines.

At one of the houses we visited we asked the staff member on duty how hazardous chemicals (COSHH) were being stored. We found chemicals including bleach and ant powder were being kept in the kitchen in an unlocked cupboard. There had been no risk assessment or checks carried out in relation to the storage of these hazardous items. We discussed this with the member of staff working at the house who recognised that these products should not have been stored as they were. They told us they were confident there was no risk to the people living at that house who would understand these items were unsafe. We made the registered manager aware who told us there had been no risk assessment as it was local policy that hazardous products were not kept within people's homes. They informed us these items had been removed the next day and that the team leader would discuss requirements in relation to COSHH with staff team .

During the inspection we noticed that bed rails in place on one person's bed were worn. This would make them harder to clean and increase risk of the spread of infection. We raised this concern with the registered manager who told us they would address this matter. We received evidence that replacement bed-rails had been purchased shortly after the inspection.

We looked at staff personnel files to determine what steps the service had taken to help ensure only staff of

good character had been employed. We saw staff had been interviewed, had completed an application form detailing a full employment history and had undergone a disclosure and barring service (DBS) check. DBS checks highlight whether an applicant has any convictions or is barred from working with vulnerable people, and helps employees make safer recruitment decisions. We also saw that all staff had two validated references on file and identification as is required.

Everyone we spoke with told us they felt safe in their homes being supported by the staff. We saw copies of the local authority safeguarding policies were available for staff to refer to. Staff we spoke with were aware of how to identify and report any safeguarding concerns they might have following appropriate procedures. One member of staff told us; "I'd record any concerns and would inform the manager." The service kept a log of any safeguarding referrals they had made, and had informed CQC as required.

Each house we visited had a file containing a 'disaster plan', which contained details such as emergency contacts and procedures to follow in the event of an emergency or if an evacuation from the property was required. The file also contained copies of the fire risk assessment and records of regular checks carried out by staff in relation to the safety of the environment and equipment at the home. This included checks of bedrails, fridge temperatures, water temperatures and hoist slings.

Staff showed an understanding of supporting people to take considered and controlled risks. For instance, one member of staff talked about discussions that had been held about putting in place a support plan to develop one person's skills to enable them to travel and access the community independently.

There was evidence that people had been involved in and understood risk assessments relating to their support. For example, we saw recorded support sessions had been carried out where staff had discussed the fire evacuation procedure with people. We spoke with one person about accessing the community independently. They, and the member of staff supporting them were both aware of the guidelines to follow in relation to community access and at what point concerns would be escalated if they had not returned home and had not contacted staff.

Good

Is the service effective?

Our findings

We saw people were able to help themselves freely to food and drink. People's care plans contained information on their dietary needs and preferences and we observed staff consulting with people about what they wanted to eat for meals that day. The staff we spoke with were aware of the support people required to eat and drink as documented in their care plans. We were present at one person's home whilst staff supported them with a meal. The staff member sat discreetly observing this person whilst they were eating their meal. This was in accordance with guidelines contained in this person's care plans and was in accordance with the advice of a speech and language therapist (SALT). Where a need had been agreed, we saw staff had monitored people's food and fluid intake. However, the records we saw did not always provide details such as the consistency of the meal provided where this would have been relevant information.

We found the consistency with which staff received regular supervision varied across the service. One service manager told us that supervisions should be carried out four to six weekly. Most staff confirmed they received regular supervision. However, staff at one property in Wigan told us they had not had supervision for some time. Not everyone's supervision documents were available for us to review as these were kept securely by team leaders. One staff member said; "I have a regular one to one with a senior, every three to six months. It's good because you can discuss any issues and can put forward concerns. Me and my senior have a good relationship." Staff reported they felt adequately supported and they told us team leaders worked alongside them frequently. We saw examples of where supervision had been used as an effective mechanism to identify support and training requirements for a staff member to develop their confidence and competence in their role.

We checked the training matrix, which showed training had been undertaken in areas including safeguarding, mental capacity, health and safety and moving and handling. Some staff had also undertaken training in autism awareness, epilepsy and effective communication. This training would be important for staff to provide effective support to certain people supported by the service. The training matrix indicated there were some gaps where refresher training was overdue or where staff had not yet received training, such as in first aid and challenging behaviour/positive behaviour support. The registered manager told us the training matrix was not completely up to date due to the absence of the training co-ordinator at that time. Staff told us they felt they had received a sufficient amount of training to undertake their roles competently. They told us they were able to request to attend additional training courses if they felt this would be of benefit to their practice.

We asked one staff member who had been recently recruited by the service to tell us about their induction. They told us they had worked alongside another staff member for two to three weeks and had met with their manager on a regular basis who had also observed their practice. They told us they felt their induction had sufficiently prepared them for the role when they started lone working. The Stockport service manager told us the staff team had been newly recruited when Wigan DCA had taken over the service. We saw evidence that staff had undertaken a range of training during their induction and there had been regular discussions and competency checks undertaken with staff. Records in staff members' personnel files showed their competence to lone work had been checked and signed off by the manager at the end of induction period.

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.

The registered manager told us no-one supported by the service had an authorised deprivation of liberty in place. They showed us evidence that 'screening tools' had been completed to identify potentially restrictive practices. These had been shared with the local authority who would support the service in making applications to the Court of Protection to apply for an authorisation if required. The registered manager said that if there were any concerns about a person being deprived of their liberty that the first step would be to arrange a best interests meeting with relevant people involved in that person's care. The registered manager told us there was no current use of physical intervention or restraint within the service. They told us that if physical intervention was required that it would only be used as a last resort and in agreement with a multidisciplinary team following a best interests process.

Staff were able to demonstrate an understanding of capacity and consent and how this related to the support they provided to people. Managers and team leaders spoke about involving advocates when required and gave examples of how advocates had been involved in best interest decision making. Care plans contained capacity assessments and a good level of detail about how staff should support people to make decisions. This included information such as how best to support people to understand and communicate decisions, including consideration of factors such as the best time of the day to ask the person questions, and the best way to present choices. We saw the new paperwork being introduced also prompted staff to follow best-interest decision making procedures should significant decision affecting the person be required and where the person lacked capacity to make the decision themselves.

People told us staff supported them to attend health appointments and regular check-ups such as appointments with the dentist. There were health action plans in place in people's care files that detailed people's health needs and how best to support them to ensure these needs were met. This included information on people's dietary needs and how to support people to attend appointments. Records of appointments showed a range of health care professionals had been involved in people's care.

In two instances we found records in relation to the support people were receiving in relation to their health were not clear and complete. In one person's care file, the 'check-list' of health appointments attended was out of date. The staff member at that house told us the checklist may need updating due to care plans moving to a new format. Another person's health action plan identified that staff should carry out a skin check to ensure there was no sign of any pressure damage. Staff we spoke with were aware of this requirement and told us this was done. However, there was no record of this check kept. The registered manager informed us shortly after the inspection that this had now been implemented.

The homes we visited were clean and well maintained. Service managers told us any repairs were reported to the landlords, and we heard staff making calls to log repair requests during the inspection. We saw there was appropriate equipment in place to support people, such as ceiling 'tracking' hoists for people who required this support.

Good

Is the service caring?

Our findings

We asked one staff member if they would be happy for a family member or friend to be supported by Wigan DCA. They replied; "Yeah. They [the service] really go full out for the people they support." The registered manager told us that whether the service would be suitable for a family member was the guidance they followed in managing the service.

Staff demonstrated a person-centred approach to supporting people to engage in activity and develop their independence. One member of staff said; "You don't take over. I know [person] can make their own brew. I read the support plan and get to know people's capabilities." Two members of staff we spoke with talked about supporting people living in one of the houses, including a person with a profound learning disability, to engage in both leisure activities and day to day tasks around the home. They told us they had supported one person to develop the skills to be able to make a cup of tea with minimal support. They also said this person had started to get their cup when they wanted a drink and talked about this as being a positive step in developing their independence and communication. The service manager talked about the staff team being committed and determined to supporting people to achieve positive outcomes.

People we spoke with also told us that staff supported them to be as independent as they could be. One person told us; "I help do my tea," and staff told us other people were involved in preparing their meals and carrying out household tasks. We observed people being provided with an appropriate level of support to enable them to carry out tasks such as making drinks as independently as possible.

People told us they got on well with staff and told us they knew the staff who provided support within their homes. One relative we spoke with told us; "The house manager is excellent. They are compassionate, caring and they work extremely well. [Family member] is really engaged with their key-worker." Staff and relatives confirmed there were 'core' staff teams who tended to work with the same people on a consistent basis.

Although the people we spoke with told us they had not been involved in interviewing staff, we saw evidence that other people using the service having been involved in the recruitment of staff. This would help ensure people had a say in who provided support to them. One of the service managers told us people were supported to come up with their own questions for interviewees, and pictorial documents had been produced to support people's involvement in the interview process. We saw 'matching tools' had been completed for staff in order to help identify which staff and people using the service would work best together. We discussed with managers the extent to which it was possible to 'match' staff. One manager told us there were practical limits to the extent with which this could be done, but said they did take such factors into consideration when putting together staff rotas.

During our visits to people's homes we saw positive interaction between staff and the people they were supporting. We observed staff chatting with people about their plans for the day, people's interests and laughing and joking together. It was apparent from these observations that staff knew the people they were supporting well. At one of the houses there was limited interaction between the staff member and the

person they were supporting. However, this was in accordance with their stated preferences in their care plan.

Care plans contained a good level of detail to support staff to communicate effectively with people. This included information on how the person communicated important things such as if they were hungry or unhappy. The people we visited were able to communicate effectively verbally with the staff on duty. Staff we spoke with supporting people with limited spoken communication told us they would use non-verbal communication, such as offering visual choices or observing people's behaviour to support effective communication. Some staff had received training in communication, and one staff member told us they supported communication with one person they worked with using simple signs they understood, such as the sign for lunch.

We saw there was some accessible information, such as pictorial documents available to people using the service. This included a pictorial information about safeguarding and United Response. In one person's care file we also saw a short pictorial version of their care plan, which would help them understand and be involved in the care planning process. We saw there was documented involvement of people and their relatives where appropriate in developing or reviewing care plans. Relatives and people we spoke with confirmed this was the case.

People told us staff respected their privacy. Staff told us they would knock on people's doors before entering their room, would ensure doors were shut when providing support with personal care, and would allow people their own space. People we spoke with confirmed staff respected their privacy. One person said; "I like to be on my own in my room and listen to music. Staff knock on the door if needed." Another person told us; "They've never been in my room when I'm not decent."

Good

Is the service responsive?

Our findings

People supported by the service were involved in a variety of activities. People had activity schedules in place in their care files that had been developed around their preferences, and detailed the regular activities they took part in. Staff supported people to take part in activities including day to day tasks around the home, shopping, and leisure activities such as going to the cinema or club nights. Staff told us they would support people's involvement in the local community by using local facilities, such as libraries and banks. One member of staff told us it helped that they knew the local area well, and knowing the location of public toilets for example, allowed them to support people more effectively outside the home.

Some people supported by the service attended day services or undertook paid or voluntary employment. One of the service managers told us the provider had a supported employment team, and we saw the quarterly audits undertaken by the service managers prompted consideration of supporting people to access employment and voluntary opportunities. We also saw evidence in people's care plans that demonstrated employment and education opportunities had been discussed with people.

The service supported people to maintain social and personal relationships. For instance, we saw one person had a goal identified in their care plan to maintain their relationship with their partner. Relatives we spoke with told us they were able to visit their family members without restrictions. One relative we spoke with said; "They have said I can come at any time. Staff are very good and keep me informed." We spoke with the team leader at the Stockport service who told us they had arranged a 'keep fit' group held at a local venue and was open to all people using the service.

We saw people's care plans identified goals, and the staff we spoke with were aware of these goals. Goals did not always identify clear timescales or the steps required to support the individual to achieve the identified aim. However, staff were able to clearly explain the process they would follow, which would include holding 'support sessions' with the person to discuss the practical steps required for them to achieve them their goal. One staff member told us goals they had recently supported people to achieve included one person going to watch a music concert and another person who had a goal to go on more holidays.

There was a service user guide that included information for people in pictorial format about how they could raise a complaint. People and relatives we spoke with told us they would feel confident raising a complaint if they had any concerns. One person told us they would; "have words with the boss," if they were unhappy. Relatives we spoke with told us they had no complaints, but that they would feel comfortable approaching a member of staff such as one of the team leaders to raise a complaint if they felt this was necessary. The registered manager told us one complaint had been received by the service in the past 12 months. We discussed the complaint with them and they informed us they had been unable to resolve the complaint at that time. We viewed correspondence that showed the service was in discussion with the local authority in relation to the complaint raised and was taking appropriate actions.

At the Stockport office we saw there was a steady stream of people who used the service and family

members who came freely into the office. We saw that both people and their families were comfortable openly discussing any concerns, queries or support needs they had with the service manager and team leader. We saw the staff took the time to listen to people and to try and effectively resolve any issues.

The provider had recently introduced a new format for care plans. The care plans we saw were at different stages of being moved over to this new format. Care plans had been recently reviewed and were comprehensive and person centred. They were written in a way that would help ensure staff reading the care plan were aware of the person's support needs and preferences in relation to a wide range of health and social care support needs. We saw people's social histories had been recorded various person centred planning tools had been completed. These provided information including what/who was important to the person, how they should be supported to help ensure they had a good day, and information on the persons interests and strengths. Staff we spoke with were aware of people's preferences in relation to their support as well as their interests and hobbies as recorded in their care plans.

Relatives told us they thought the service was effective at responding to their family member's changing needs. Two relatives told us they felt their family members could sometimes present challenges to the service and the staff who worked with them. They told us they thought staff responded very well in such situations. A third family member talked about how their relative had changed 'dramatically' over the years. They said; "They [Wigan DCA] have embraced that change in a compassionate and caring way."

People told us they were able to make day to day decisions such as when they went to bed and what they ate for meals. Staff told us they would ask people what they wanted when doing the shopping and would support people to make choices by presenting 'either, or' choices visually where this would be helpful to the individual.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. The registered manager told us they were responsible for the management of Wigan DCA as well as another location they were temporarily overseeing in the Manchester area. The registered manager was supported by one service manager for the Wigan and Salford areas and one service manager for the Stockport area, who were in turn supported by team leaders. The registered manager told us they felt they had sufficient support to be able to manage both services effectively.

Regular checks were carried out at each house to help ensure the safety of the service. This included regular checks of people's finances, the safety of the environment and medicines. These checks had been carried out consistently as required at all but one of the houses we visited, where there had been an unexplained gap of three weeks in the weekly medicines check. We made the registered manager aware of this and they told us they would address this with the staff team.

A quarterly audit was carried out by the service managers for each property. These audits covered a wide range of checks, including a check of supervisions, care plans, medicines, risk assessments, health and safety and staff practice and knowledge. They were also used to ensure the regular checks carried out by staff were being undertaken as required. The audits identified time-scales and the staff member responsible for following-up any actions identified. Prior to our inspection the registered manager had sent us a copy of the annual satisfaction survey carried out by the provider. The survey sought the views of people using the service, friends/relatives and professionals. Results of this survey were predominantly positive, and any areas with less positive findings had been highlighted for follow-up and further investigation. The registered manager also provided us with a copy for the results specifically relating to the Greater Manchester area services. This information would help the registered manager identify where any areas of improvement were required within the service.

The registered manager told us the provider had a scheme where people using the service were paid to undertake a 'quality check' of the service and produce a feedback report. They told us this would be shared with them and more senior managers within the company and would feed into the quality assurance process. The registered manager told us the feedback they had received from any such visits had generally been very positive and had not identified any specific areas for improvement at this time.

We saw the service managers kept records of any incidents or accidents that occurred. One of the service managers told us they would monitor the accident reports they received and would identify if any further actions were required. They showed us a recent example of where an individual had been referred to the falls team as the service manager had identified that they had experienced two falls in close succession. We could also see they had discussed falls prevention with the staff team. The service manager told us the accident reports were also sent to head office who also monitored for any trends that might indicate further investigation or action was required.

Staff told us they enjoyed working for the service and some of the staff we spoke with had worked for the

service for many years. One staff member said; "I'm happy, I love my work." Another staff member told us; "We've got a good rapport with the manager and feel happy to raise any concerns. We feel like we can talk to the managers openly and I had a good useful induction to the service. We get good managerial support." The registered manager told us they had worked for United Response for 20 years and told us they wished it had been longer. The service managers told us they found the provider was responsive to their requests for resources they required to make improvements to the service.

Staff told us they felt they were listened to and were able to approach their manager to discuss any concerns they may have. We saw team meetings were held with team leaders on a regular basis, and team meetings with staff teams at each house were held with variable frequency.
There were arrangements for on-call support from a manager to be available out of core working hours. Staff we spoke with told us they had never had an issue contacting and getting a response from the on-call when required. We saw there were computers located in the staff rooms at the properties we visited. The registered manager told us all staff had been issued with email accounts and log-in details, which would help with effective information sharing with the staff teams.

The registered manager listened to and took prompt actions based on the feedback we provided during and following the inspection. For example, the issue in relation to the safe storage of COSHH at one house was resolved the same day we made the registered manager aware of this. We also provided feedback to the registered manager that one person's bed-rails appeared old and worn and the registered manager provided evidence that replacement bed rails had been purchased shortly after the inspection. We also noted that the presentation of one person's pureed meal could have been improved, although they still appeared to have enjoyed the meal. The registered manager contacted us following the inspection to inform us the service manager had purchased food moulds, which would help improve the presentation of pureed meals in response to this feedback.