Lifeways Community Care Limited

Lifeways Community Care (Halifax)

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Lifeways Community Care (Halifax) provides support for people with a range of disabilities and complex needs. The service provides domiciliary care services, extra care housing services and a supported living service for people living across West and North Yorkshire and Lancashire. The service aims to enable people to live independent and dignified lives, by the provision of care within their own homes. Care is adaptable to suit each person's needs, and ranges from a few hours each week to 24 hour care and support.

On the dates of the inspection, 12 to 19 June 2015, 76 people were using the service. At the last inspection in January 2014 the service was compliant with all the standards we looked at.

Summary of findings

A registered manager was not in place. 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. The last registered manager had left in June 2015, and a new manager had just been recruited, who the service director told us would shortly apply to register with the Commission.

People and their relatives all told us that they thought the service was safe and nobody raised any safety related concerns. Staff understood how to identify and act on any concerns to keep people safe. Documentation we reviewed showed that safeguarding concerns were fully investigated by management and where shortfalls were found measures put in place to continuously improve safety.

Staffing levels were in line with commissioned hours. People and their relatives all said staffing levels were sufficient to ensure safe care, and staff raised no concerns in this area. Safe recruitment procedures were in place which included checks on candidate's backgrounds to ensure they were of suitable character to work with people with learning disabilities. People who used the service were also involved in the recruitment process to ensure they helped select their carers.

Medicines were safely managed. Documentation showed people received their medicines as prescribed and regular checks were undertaken to ensure that good medicines practice was consistently maintained.

Staff received regular training in a range of mandatory subjects relevant to the care and support the people they supported received. Staff we spoke to demonstrated a good level of competency about the subjects we asked them about indicating the training had been effective.

Staff and management understood how to operate within the legal constraints of the Mental Capacity Act (MCA). We saw evidence that where people lacked capacity, meetings were held to ensure decisions made were in the person's best interests in line with the requirements of the Mental Capacity Act (MCA).

Staff we spoke with had a good understanding of people's healthcare needs and we saw evidence people had access to a range of health professionals. However information about people's health conditions was not always present within people's support plans. This meant there was a risk of inconsistent support in meeting their health needs. Health action plans were also not always robustly completed. A health action plan is a personal plan about what people with learning disabilities need to do to stay healthy.

People and relatives all told us that staff were kind and caring. Through discussions with staff and observing care we observed this was the case and staff showed a motivation to delivering kind and compassionate care. Staff spent regular time interacting with people and were able to develop close relationships with the people they cared for.

People had a range of health and support plans in place to help staff meet their needs. These included relevant information to help ensure people's basic care and support needs were met. Although some people had well defined and relevant goals and objectives and performance against them was regularly evaluated this was not always the case. Some people had goals which did not match their present circumstances or there was a lack of proper evaluation of progress against set goals.

People and staff spoke positively about the management of the service and said they were good at dealing with any concerns or queries.

A range of audits and checks were undertaken by team leaders, service managers and the quality team. These were routinely identifying issues and action was taken to improve the service. However, some actions from audits conducted in 2014 had not been fully rectified within the set timescales.

Summary of findings

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. People told us they felt safe whilst using the service. Staff we spoke with understood how to identify and manage risks to people's health and safety. Where safety related incidents occurred, these were appropriately investigated to help prevent a re-occurrence.

We found medicines were safely managed. Clear records were in place which showed people received the medicines they were prescribed. Regular checks were undertaken to ensure medicines were given correctly.

Staffing levels were sufficient to ensure people received appropriate care and support. Safe recruitment procedures were in place to ensure staff were suitable to work with people with learning disabilities.

Is the service effective?

Requires improvement

The service was not always effective. Although staff displayed a good understanding of people's healthcare needs, information on how to manage people's health conditions was not consistently present within support plans. Health action plans (a personal plan about what people with learning disabilities need to do to stay healthy) were not consistently completed.

Where the service suspected people lacked capacity to make decisions for themselves , Mental Capacity Assessments were completed and best interest decisions were made in line with the requirements of the Mental Capacity Act.(MCA)

Relatives spoke positively about staff. Staff demonstrated a good level of knowledge about the people they were caring for and received a range of regular training opportunities which they spoke positively about.

Is the service caring?

Good

The service was caring. People and their relatives said that staff treated them well and were kind and caring. Our observations confirmed this to be the case. From speaking with staff were concluded staff were motivated to providing a caring service to people who used the service.

People's likes, dislikes and preferences were recorded within their care plans. Staff we spoke with demonstrated a good knowledge of the people we asked them about and how to provide appropriate care.

Advocacy services were available to people and the service had taken steps to involve service users in advocacy support.

Is the service responsive?

Requires improvement

The service was not always responsive. In some cases we found people had well defined goals to promote independence and life skills and found evidence

Summary of findings

these had been achieved. However for some other people, goals were out of date and not relevant to their circumstances or the progress against them was not being robustly evaluated. Some relatives and staff also thought the service could be more creative in the provision of activities and the setting of goals.

Appropriate support plans were in place to help staff meet people's needs in areas such as mobility, personal care.

Is the service well-led?

Requires improvement

The service was not always well led. We found the management of the service was open and honest with us and showed a desire to make continuous improvement to the service. People and their relatives generally spoke positively about the quality of management at the provider.

A range of audits were in place which were regularly identifying issues and in in order to drive improvement. However although the audits had identified some issues we identified during this inspection, they had not all been fully resolved within timescales set by the audit.

The service sought people's feedback through regular resident meetings, service user forums and periodic surveys. We saw evidence people's views were used to drive further improvement of the service.

Lifeways Community Care (Halifax)

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.

At the last inspection in January 2014, the service met all the standards we looked at.

This was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure appropriate management were present. The inspection team consisted of two inspectors, a Specialist Advisor in Learning Disabilities and an Expert by Experience who made phone calls to people's relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place between 12 and 19 June 2015. We visited the provider's office on 12 June 2015 and made phone calls to staff and relatives between 15-19 June 2015.

We spoke with 18 people who used the service or their relatives. This was a mixture of telephone calls, and visits to people's homes. We spoke with eight support workers, two service managers and the service director. We looked at people's care records and other records which related to the management of the service such as training records and policies and procedures. As part of the inspection with also spoke with the local authority commissioning team.

We did not ask the provider to complete a Provider Information Return (PIR). 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. Before the inspection, we reviewed all the information held about the provider and spoke with the local authority to share information about the service.

Good

Is the service safe?

Our findings

People told us they felt safe whilst staff supported them. One person told us "They treat me very well and I am safe with all the staff because I know them." A relative said "All the staff are kind and caring, they all know their jobs." Relatives we spoke with also said they thought people were safe in the service. Staff we spoke with did not raise any concerns about the people they cared for and told us they thought people were safe.

Prior to the inspection we received a complaint that finances were not appropriately managed by the service. This had been investigated by the provider and a number of recommendations put in place. We saw these had been implemented and there was now clearer accountability and evidence finances were managed in line with the provider's policy. Relatives we spoke with all told us that they thought finances were appropriately managed for example one told us "They're very good at book-keeping so there are no issues." All people's income and expenditure and household accounts were clearly documented with receipts and the reasons for expenditure clearly documented. Senior management conducted a monthly audit of each individual account and the combined household budget. Where staff made beverages and had meals at the accommodation a financial contribution was made to the household budget and accounted for as additional income in line with the policy. We saw when staff were supporting people in social, leisure or community activities people had on occasions agreed to pay for beverages, snack and meals. We saw the provider's policy was adhered to in terms of limiting costs.

Safeguarding procedures were in place and we saw evidence these were followed. Where allegations of abuse had been identified, correct procedures had been followed including reporting to the Commission and Local Authority, involvement of external social care professionals and undertaking investigations as appropriate. We spoke with support staff who demonstrated a good understanding of how to protect vulnerable adults from abuse. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact such as the local safeguarding authority if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with their manager knowing that they would be taken seriously. A dedicated whistleblowing telephone line was in place to support staff confidentiality.

Staff we spoke with had a good understanding of the risks presented by each person and how to keep them safe. Risks to people using the service were identified from the beginning of the assessment process. This included risks to the person, risk within their home to carry out daily living and some risks in the community. Generally records confirmed risk assessments were thorough and a conversation with people and staff confirmed the written record reflected reality. We found some people's risk assessments were not as thorough and needed more information to be present for example more detail about the risks presented when they went out into the community, however the staff we spoke with demonstrated a good in depth knowledge of the risks presented to people.

Where safety incidents occurred we saw appropriate action was taken to investigate to keep people safe. We saw there was a culture to report minor incidents and near misses as well as more serious incidents. This helped management to be aware of issues across the service and ensure actions were put in place before things became more serious. Behaviours that challenge were logged on a dedicated sheet, helping staff to understand people's triggers and take effective action.

Disciplinary processes were in place and we saw evidence these had been followed. A range of emergency procedures were in place such as missing person protocols to help keep people safe.

Key safety checks on items such as electrical items, fire, safety , food safety and lifting equipment were done on a monthly basis to help keep people safe.

Relatives we spoke with told us medicines were appropriately managed and did not raise any concerns. We looked at the administration, storage and management of medicines. Some people had the capacity to self-medicate which showed the provider was helping to maintain and develop their independence. We saw medicine administration records (MAR) were consistently fully completed. Each person had 'as required' (PRN) protocols in place which were adhered to. Medicines were safely stored in locked cabinets in each person's bedroom. We

Good

Is the service safe?

saw records existed to demonstrate medicines of no further use were accounted for and returned to the pharmacy for disposal. We saw audits of medicines to account for stock levels. There was a homely remedies procedure available for staff to refer to. Staff told us if people bought 'over-the-counter' medicines they would on behalf of people check with a pharmacist to ensure no contra-indications existed with people's prescribed medication. Where medication errors had occurred investigations were undertaken, including seeking medical advice.

We saw staffing levels were in line with commissioned support hours and these were consistently received from week to week to enable staff to provide safe care. Staff we spoke with all said there were always the required numbers of staff present within the supported homes to keep people safe. Relatives told us the homes were always appropriately staffed for example one relative told us "There are enough staff and it's safe from that point of view – there is a good rota for staff." We saw staffing levels were responsive for example if people wanted to stay at home, arrangements were made to increase staffing levels in their home. Due to the nature of the support staff had time to spend periods of time with people to ensure social interaction.

Safe recruitment procedures were in place to ensure staff were suitable for the role. This included ensuring a Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work. Recruitment focused on staff understanding of safeguarding and dignity and respect to ensure staff had the right attitude for the role. Potential new staff also met with people who used the service as part of the interview process. This was an additional check on their suitability for the role; to ensure people liked them and they could interact well with them.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us people had access to health professionals such as GPs or dentists if they needed to. Relatives told us how the service knew their relatives' health needs very well and how to care for them. One relative told us how their relative had to go to hospital and they said Lifeways had reacted appropriately and did exactly what they should have to support their relative in terms of calling a doctor and getting them to hospital. Relatives said the service always rang them "straight away" if any health concerns were identified. Information about people's healthcare needs was kept within a dedicated folder. It provided evidence of discussions with health professionals such as dentists, doctors and nurses. However although the staff we spoke with had a good understanding of people's healthcare needs we found person centred information about people's health conditions was not always provided within support plans. Some information was present in the form of generic information sheets but some people had conditions which varied greatly from person to person. In one case a staff member was able to describe how they had researched a person's health condition on the internet, but there was no dedicated information present in their support plan. This meant there could be inconsistencies in the support provided dependant on which staff were on duty. Without specific support plans on how these conditions could be appropriately managed, there was a risk staff would not manage the health condition appropriately over time.

We found health action plans were not consistently fully completed. A Health Action Plan is a personal plan about what people with learning disabilities need to do to stay healthy. It lists any help that they might need in order to stay healthy and makes it clear about what support they might need. We visited one supported living house and looked at three people's care files. Although these people had health action plans, none of them were fully completed to clearly describe the support these people needed in order to stay healthy. We found these findings were replicated in other supported living properties we looked at with inconsistencies in the quality of health action plans. Following the inspection the director of the service told us they would take immediate action to address.

Relatives told us staff were appropriately trained to ensure they provided appropriate care. Staff told us they received a variety of training from the provider and reported it was effective in giving them the skills they needed for the role. Staff received training in the core competencies which included health and safety, food hygiene, safeguarding, medicines and fire safety and the majority were up-to-date. Knowledge checks were undertaken around key topics such as safeguarding to ensure staff displayed the required level of competency. We saw evidence staff received more focused training to meet the specific needs of the people residing at the houses. This training included diabetes, epilepsy and autism. This was confirmed by relatives for example one relative told us staff had received autism training to ensure they cared appropriately for their relative. New staff received a full induction based on the care certificate standards. We spoke with a new member of staff who described the induction as "brilliant." They said they were new to learning disabilities care but the training was comprehensive and gave them the correct skills. A local induction to people's care needs and the house was also in place. A programme of regular supervision and appraisal was in place. We saw this supported staff to further development and evaluated how effective they were in their role.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We saw there were policies and procedures in relation to the MCA and DoLS to ensure people who could make decisions for themselves were protected. Staff we spoke with told us they had attended training and showed a good understanding of MCA and DoLS. We saw records of when people had formally agreed to consent to have their needs shared with others. For instance one person had consented to share information with a close relative to allow staff to contact them if there was any decline in their health. We saw evidence that where people did not have capacity to make decisions themselves a best interest process had been followed in line with the requirements of the MCA to ensure decisions made for people were made in their best interest. Documentation we viewed contained clear information on how the decision was derived and evidenced a multidisciplinary approach.

We saw staff promoted and respected people's choices and relatives told us this was the case. For example one relative told us that the service understood their relatives'

Requires improvement

Is the service effective?

preferences and responded to what they wanted to do. Daily records evidence that people had been offered choices, for example around activities of daily living and during observations of care we saw people were offered choices and their choices were respected.

Relatives we spoke with told us people were supported appropriately at mealtimes. Menu planning was undertaken in each individual house and we saw for example, people were included in planning mealtimes to ensure food met their preferences. Eating and drinking care plans were in place which described the level of support people required. People were periodically weighed although the support plans often did not state how often this should be. We found in one house a person of low weight had not been weighed since April 2015 despite staff telling us they should be weighed monthly. The staff member told us the scales were broken. Following the inspection we saw the provider took action to ensure these were promptly repaired, however we were concerned that this issue had not been appropriately reported to and rectified by management sooner.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring and treated them well. One person told us "Happy with it, key worker is amazing." Another person said "They treat me very well and if I want something special they do it for me." A relative told me, 'I'm fairly happy. He's happy, thriving and achieving and that's the main thing. I know I can go away and he's well cared for."

Relatives told us there was a well-defined process when people moved into the house to ensure it was suitable for them. This included several visits to the house to meet staff and other people to ensure a smooth and comfortable transition and to ensure that the service could meet their needs.

During visits to people's homes, we observed interactions between people and staff. People appeared calm and relaxed in the company of staff. Staff treated people well, calmly and patiently explaining things to them and comforting them when necessary. Care staff understood the importance of promoting people's independence and dignity. People's care records clearly stated what they could do for themselves and what they needed help with. A person told us "I do my own washing and clean my room but I don't iron, the staff do that for me." Relatives said people were encouraged to take responsibility for keeping their own rooms clean and tidy, and to help with household chores; this was consistent practice throughout the service. There were several examples of staff supporting people to do household chores and maintain or develop independence in this way: One person told us their relative "helps changing sheets. She's very tidy. The staff say it's like having another member of staff." Another relative said his relative 'peels the potatoes, does the washing up – she enjoys doing it."

We observed staff supporting people in a positive way. Some people living at one home we visited had Autistic Spectrum Disorders (ASD). We saw staff interacting with people with a structured and therapeutic approach. Staff were helping people to develop social and life skills and manage stress. Staff communicated in a way which helped them understand what others may be trying to communicate to them. We saw the service used schedules and timetables to give the necessary structure and visual cues to people with ASD. It was clear from conversations with staff that they had a good knowledge of the people they were caring for and were able to tell us in detail about people and their preferences, likes and dislikes. Relatives also told us this was the case, for example one relative told us staff were "very good and know him well." Due to the way the service operated, staff spent extended time interacting with people and were able to develop close relationships with the people they were caring for.

Well defined policies were in place which ensured advocacy support was provided when needed. No one who used the service at the time of our inspection had been identified as needing a lay advocate to help them to express their wishes about their care. However, staff told us of instances where an advocate had been used to assist people with pivotal decisions. We saw information on advocacy had provided to people and one service user was receiving guidance to enable them to act as an advocate for others.

A copy of people's care plan was kept in the office of the registered provider and a copy was kept at people's own homes. This was confirmed by people and staff. Staff updated care plans and signed them. We saw a number of format variations to people's care plans which reflected people's wishes. In one case the person said they did not wish to have a formal care plan but wanted on-going dialogue with staff to meet the person's changing aspirations. In another case we spoke with the parent of one person who had taken the lead compiling a new care plan for their relative. They told us they had made the staff aware of their relatives new care plan and were confident their wishes would be met.

People and their relatives generally said they felt listened to and involved in the service. Family communication sheets were in place to ensure contact with families was robustly documented. We saw that people had regular contact with family members either by visits or by phone and people were supported to go and stay with their relatives for short breaks.

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Requires improvement

Is the service responsive?

Our findings

Care and support plans were in place, these included person centred plans which focused on people's likes, dislikes, preferences and included personalised information. Support plans covered areas such as mobility, eating and drinking, personal safety and social activities. These provided detailed information on how staff should care for people.

We found some people had well defined goals for independence. These people were encouraged to follow their own interests and activities to enhance their life-skills and means of enjoyment. For example one person told us "They helped me set new goals. I wanted to go to America and a few weeks ago I went with my support worker." They showed us photographs from the holiday and were clearly delighted with the experience. They told us it was their choice to go on the holiday which had fulfilled a long held ambition to go to America. They also told us they wanted to learn to drive and staff were helping them to do that too. A relative of another person told us "they take him out all the time" and said their relative did a range of activities including rock climbing, swimming and going out for meals.

However we found there was a general inconsistency in terms of defining and evidencing the achievement of goals to develop people, their independence and their experiences. Although people had person centred action goals in place, these were not consistently up-to-date and or relevant. For example for two people their goals had not been re-written since 2012 and 2013, and their goals did not always contain well defined steps to achieving those objectives. Monthly evaluations often listed what they had done rather than evaluating goals. For example one person's support plan written in 2012 stated they wanted to go horse riding. Recent activities showed that they had not done this but the care plan had not been updated to evaluate why. Although staff said they were expanding their goals based on new transportation options this person now had this was not recorded within their goals/objectives. This person's relative also raised concerns that their relative was not doing enough and their goals were not met. In other care records we also found that when goals had been achieved new ones were not consistently put in place to develop people further. Each support plan also had a short term and long term goal section but the evaluations had not been completed. This made it difficult to track whether people had achieved the goals set out in their support plans.

We found this inconsistency in achieving goals and outcomes especially in terms of activities was replicated in sentiment from some staff and people who used the service. Some relatives reported there was no creative or empowering person centred activities, one relative told us the girls are often 'just plonked in front of the telly" and didn't feel that enough activities were provided. One staff member we spoke with told us activities were poor and people in their house did the same things and that staff had not thought creatively about how to remove barriers to ensuring varied support. They told us they didn't think people's goals were evaluated as often as they should. Other staff and relatives spoke positively and told us how they had supported people to attend salvation army, employment, church and holidays.

There was a lack of consistency with regards to evidencing client involvement. In one service we saw people had been totally involved in their planning because they had signed and dated the support plan, however other support plans did not robustly evidence involvement.

We saw the provider had recognised some of these problems, new paperwork was being introduced by the provider which they told us would ensure a more person centred approach to care planning. They told us this was being introduced as a matter of priority.

Detailed notes on people's daily living were in place. These provided evidence that staff attended to their care needs such as personal care, what they had to eat and drink and undertaking some activities and social interaction. They evidenced that people had been asked what they wanted to do on a daily basis. These were detailed providing evidence that staff provided a high level of care and support to people. Night monitoring checks were also in place where needed to ensure people were monitored who needed to be.

The relatives we spoke with felt they could make a complaint if they needed to. People said where they had raised issues with Lifeways, they had been listened to and Lifeways had responded positively. We saw one complaint had been received in 2014 which the Commission was aware of, although this had not yet been fully resolved to

Requires improvement

Is the service responsive?

the satisfaction of the complainant. We saw improvements in some specific areas had been made following this complaint for example to the way finances were managed. No other complaints had been received indicating a general high level of satisfaction with the service. A number of compliments were also in place which provided information on where the service had exceeded expectations.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection, a registered manager was not in place. The previous registered manager had left in June 2015. We spoke with the director of the service who confirmed a replacement had been recruited who would shortly apply to register with the Commission.

The provider had submitted all required notifications to the Commission for example safeguarding notifications. On occasions we asked for further information, this was always provided in a timely manner.

People and relatives reported that management was generally effective in addressing any queries of concerns they had. However two relatives told us they thought the service was disorganised at times and needed to improve the way it communicated with them about their relatives. We saw communication had been highlighted as a key area for improvement on the provider's audit system indicating the service was taking action to address.

Staff generally told us they were happy in their work and enjoyed it and that management were effective. One staff described the team as "very professional." Staff we spoke with demonstrated a motivation to their job and ensuring people were kept safe and happy. They told us the generally felt well supported by manager, although a number of staff from the Harrogate region said they felt the distance they worked from the head office in Halifax at times provided a barrier to effective support.

A quality team was in place responsible for managing systems to assess and monitored the quality of the service. A range of audits and checks were undertaken, these included team leader checks, monthly service manager audits and a full annual audit undertaken by the quality team based on the CQC standards.

Checks on finances, medication and daily notes were done by team leaders at each site. These were audited by senior management on a monthly basis. A monthly workbook was completed by the service manager which looked at key quality ratings about the service such as complaints, compliments, safeguarding and audits. Action plans were in place from service manager workbook. We looked at these audits and found good examples that a range of issues had been identified, escalated as appropriate and action plans put in place to address with the relevant staff members. However this was not consistently applied. We found actions were not always completed within the timescales stated on the audits. For example, we looked at an annual quality audit conducted for one property in June 2014. The action plan had highlighted that more specific and measurable goals be put in place for each person, within one month of June 2014. During our examination of care records we found this had not been satisfactorily resolved with a lack of specific, measurable and up-to-date goals in place for some people. The audit had also highlighted that there was a lack of information on one person's medical diagnosis within their support plan. We found this had not been resolved, and was also an issue for other people living in the house indicating the shortfall had not yet been addressed . We spoke with the director who told us that in the transition from last year's action plans to a new system of audit, monitoring of action plans had not been as robust as it could have been, but assured us following the inspection that this had now been addressed. The director also told us that the timescales for completion of audits was often unrealistic and said this would be addressed with the new system. Although health action plans were audited as part of the annual quality audit, we concluded more robust and regular monitoring was required due to the number of incomplete health action plans found across the service.

The service demonstrated a desire to continuously improve the service. Where we highlighted issues during the inspection we were provided with information stating the actions that had been taken to address . A range of further improvements to the service were planned including the introduction of more person centred care plan documentation to ensure further improvements were made.

Accidents and incidents (including safeguarding), compliments, complaints were monitored on a monthly basis from each house where people were supported and any actions to improve the service monitored. Periodic analysis was undertaken to look for any trends. Incidents were escalated through a chain of governance to health and safety, senior management and the board. Across a range of areas training, supervision, action plans were in place where deficiencies were identified. Clear actions were put in place following each incident to help improve the service.

People were involved in the running of the service through the quality focus group which was set up by people who

Requires improvement

Is the service well-led?

received support. This fed any actions into a national user focus group. People had been involved in the planning of events , advocacy and food and nutrition. Individual houses also had meetings which covered leisure and holidays. We saw records of the tenants meeting which again were in both written and easy read format. The records demonstrated an inclusive and responsive regime operated at the houses.

Annual satisfaction surveys were sent to people who used the service and their relatives. We saw the results from the 2014 survey which were generally positive with the care and support provided. Where negative comments were identified we saw these had been addressed with the individuals who provided the feedback to help ensure continual improvement.