Independent Options (North West)

Community and Housing Related Support Services

Inspection report

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Date of inspection visit:
28 September 2016
29 September 2016

Date of publication:
09 January 2017

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

This was an announced inspection which took place on 28 and 29 September 2016. The inspection was announced to ensure the registered manager or another responsible person would be available to assist with the inspection visit.

We last inspected the service in October and December 2013. At that inspection we found the service was meeting all the regulations that we reviewed.

Community and Housing Related Support Limited provides domiciliary care and support and eight supported living tenancies to adults, children and young people who have a learning and/or physical disability. The registered manager and additional management support staff were located at the company's head office in Hazel Grove Stockport Greater Manchester.

A registered manager was 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.

People who used the service and their relatives were complimentary and positive about the support provided and attitude of the support workers. They told us they were happy with the service provided and felt their needs were being met. They also told us support workers treated them caringly, sensitively and with respect and they tried to make sure that their independence was maintained wherever possible.

People were supported by sufficient numbers of suitably trained staff. We saw that recruitment procedures helped to make sure staff had the appropriate qualities to protect the safety of people who used the service and we saw they received the training and support required to meet people's needs.

Support workers we spoke with told us they had undergone a thorough recruitment process. They told us training appropriate to the work they carried out was always available to them and following their employee induction. This helped to make sure the care provided was safe and responsive to meet peoples identified needs.

Individual staff training records indicated that all support workers had received such training and were working towards a nationally recognised qualification in care such as a National Vocational Qualification (NVQ) in health and social care and the Care Certificate. The Care Certificate is a professional qualification which aims to equip health and social care staff with the knowledge and skills they need to provide safe care and support to people using the service. This qualification helped them to carry out their roles effectively. Support workers confirmed they had received safeguarding and whistle blowing training and knew who to report to if they suspected or witnessed abuse or poor practice.

Care records were in place to reflect peoples identified care and support needs. Information about how people wanted to be supported, their likes and dislikes, when support was required and how this was to be delivered was also included in the care records we examined. Information regarding people's dietary needs was included in their care records and clear guidance for support workers helped make sure these requirements were met.

We saw written evidence of people and their relatives involvement in the decision making process at initial assessment stage and during their care needs review.

Medicines were stored safely and administered by staff who had been trained appropriately to ensure they were given safely. Any specific requirements in relation to medication, such as rescue remedies for the immediate treatment of epileptic seizures, were clearly documented so that support workers could administer the medicine appropriately and were aware of any risk following administration.

Where people who used the service did not have the capacity to make their own decisions, the service ensured that decisions taken were in line with the principles of the Mental Capacity Act 2005. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Support workers at supported tenancies were visited regularly by the registered manager to check if people were satisfied with the service they were receiving and to make sure staff were carrying out their duties appropriately.

Complaints, comments and compliments were encouraged by the provider and any feedback from people using the service or their relatives was addressed by the registered manager. People spoken with knew how to make a complaint and felt confident to approach any member of the staff team if they needed to.

The registered provider had systems in place to monitor the quality of the service such as service user and relative surveys, to ascertain their views and opinions about their satisfaction of the service provided. Any feedback received was noted and used to make improvements to the service and the care and support being provided.

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.

Employee recruitment processes were in place. The required pre-employment checks had been undertaken prior to anybody starting work at the service to help make sure they were safe to work with vulnerable adults and children.

Appropriate arrangements were in place to help safeguard people from abuse. Support workers were appropriately trained and knew how to protect people from the risk of harm and knew what action to take if abuse was suspected or witnessed.

Where risks were identified detailed care plans were in place to minimise the risk of harm. Medicines were administered by support workers who had been trained to ensure they were given safely.

Is the service effective?

Good

The service was effective.

The registered manager and support workers were aware of the Mental Capacity Act (MCA) 2005 and what to do if any restrictions on people were in place. Where people were being deprived of their liberty the registered manager had taken the necessary action to make sure people's rights were considered and protected.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, who contributed to care records.

Support workers received an employment induction, regular supervision and training to make sure they had the appropriate skills to provide people with effective care and support.

Is the service caring?

Good

The service was caring.

People received care and support from support workers who

knew them well and made positive comments about the caring and supportive nature of the staff.

Relatives of people using the service knew the purpose of the care records and knew they were reviewed regularly in line with the person's changing care needs. They told us they were always included in decisions about all aspects their relatives care, and support workers helped people to express their views.

People's care records were stored securely so their privacy and confidentiality was maintained. Support workers knew how to use the service's confidentiality policy and understood how to work within its guidelines.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them receiving a service and person centred reviews were held on a regular basis or as necessary.

Detailed care records identified risks to people's health and well-being and included specialist guidance. Care records indicated people's interests and activities and people were supported to pursue their hobbies.

People told us they felt confident in raising concerns or complaints because they knew their concerns would be dealt with immediately and appropriately by the registered manager or support workers.

Is the service well-led?

Good

The service was well-led

The service had a manager who was registered with the Care Quality Commission (CQC). The registered manager promoted a positive culture that was person centred, open and inclusive.

The provider had systems in place to monitor the quality of the service.
We saw that regular audits and system checks were undertaken on all aspects of the running of the service.

The registered manager was aware of their role and responsibilities regarding their legal obligation to notify the CQC about important events that affect people using the service and the management of the service.

Community and Housing Related Support Services

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 the 28 and 29 September 2016 and the first day was announced. We contacted the registered manager 24 hours before our visit and advised them of our plans to carry out a comprehensive inspection of the service. This was to ensure the registered manager and relevant staff would be available to answer our questions during the inspection process. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed 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. We also reviewed information that we held about the service and the service provider. This included safeguarding and incidents notifications which the provider had told us about. Following the inspection we spoke with a person from the local authority adult social care learning disability team who confirmed they had no current concerns about the provider and the services that were being provided.

During our inspection we spoke with the registered manager, the chief executive officer, a person who used the service, the director of human resources, the interim domiciliary care manager and two support workers. We made telephone calls to one support worker and the relative of a person who used the service.

We looked at the care records that belonged to four people who used the service, three employee personnel files including individual staff training records, records relating to how the service was being managed such as safety audits and a sample of the services operational policies and procedures.

Good

Is the service safe?

Our findings

A person we spoke with told us they felt safe when receiving care from the staff and said, Yes I like it here. Yes I'm safe." When we asked a relative if they considered their relative was safe at a tenancy they said, "Without a doubt, he [relative] is safe and very very happy"

We saw there were arrangements in place to help protect people from the risk of abuse. The service had an up- to-date safeguarding policy and procedure in place which was in line with the local authority's 'safeguarding adults at risk multi agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records that showed the provider had effective procedures to help make sure any concerns about a person's safety was appropriately reported. Support workers we spoke with were able to give a good account of the specific risks attached to vulnerable adults and children, the safeguards in place to minimise these risks and explain how they would recognise and report abuse whilst demonstrating their understanding of the need to be vigilant about the possibility of poor practice.

We spoke with two support workers at the supported tenancy who said, "We know what signs to look out for and we know who to report too" and "The people who live in this supported tenancy have staff appointed to manage their finances. It's a very responsible position and the organisations finance department audit people's finances every three months to make sure people's money is handled appropriately and they are not victims of financial exploitation. The support workers check and sign for people's finances at shift handover. We have to keep receipts for every purchase made. It's a good system and we have to refer to the finance policy."

They confirmed they had received safeguarding and whistleblowing training. They were able to share their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by staff) and told us they would contact the registered manager to inform them about any risk concerns. Staff training records showed they had received whistle blowing training. Both support workers told us the service they provided was safe because they were aware of their responsibility to ensure people's safety, and knew how to implement the service's safeguarding procedure.

An accident and incident policy and procedure was in place. We looked at the file used to record accidents and incidents. Any reported incidents or accidents were recorded and appropriately addressed by the provider. The registered manager told us that appropriate authorities, including the CQC, would be notified immediately of such events when they occurred.

A safe and effective recruitment and selection procedure was in place. We looked at six staff recruitment files and found that all of the support workers had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and up to two recent references from previous employers. Such checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults and children.

We checked two medication administration (MAR) records and saw they provided a detailed list of all the medicines prescribed, and when they needed to be taken. Staff signed the MAR when people had taken their medicine and each MAR we looked at had been signed appropriately. A support worker told us the process following a medication error should one occur and said, "If we find there has been a medicines error such as a medicine not signed for by staff, we have to complete a medicines error report form and immediately inform the duty manager or if necessary seek advice from the person's general practitioner (GP) or NHS 111.The form asks what the error was, what the recommendations are and how the error could have been prevented. The completed form is then sent off to the Human Resources director who shares the information at the next internal health and safety (H&S) meeting. An H&S representative visits the tenancy shortly afterwards to discuss any errors at the team meeting." We examined these records and they showed that a clear audit trail was maintained to monitor people's medicine administration and medicines errors. NHS 111 is the NHS non-emergency number where people can speak to a highly trained adviser; supported by healthcare professionals should they require any health or medical advice.

We examined the care records that belonged to three people who lived in a supported tenancy and a person who received a domiciliary care service. The care records showed that risks to people's health and well-being had been identified. For each person who used the service assessments for a variety of physical and environmental risks including behavioural risk and risks in relation to lifestyle choices and activities such as visits to places of interest and daily living skills were in place. Risk was measured against the risk triggers, severity, probability and likelihood of the risk occurring. Control measures and support worker actions were included in a risk management plan which when implemented was linked into the person's support plan. For example, where there was a risk to a person of choking their risk management plan clearly identified the cause or factors which might increase the likelihood of the risk occurring. The plan stated what action the support workers should take to minimise the risk, such as making sure all food served did not contain any bones and to make sure the person's food was cut into small chewable pieces. Support workers spoken with understood these risks and risks identified in the care records of people who used the service.

Support workers within domiciliary care and supported tenancy teams, where people's behaviour was identified as challenging the service, had received appropriate training to help them manage and defuse people's challenging behaviours appropriately and safely use techniques such as distraction and removing the person safely from the situation.

The service operated a 24 hour on call service. Risk assessments were carried out to consider the effects of staff lone working in line with the service's lone working policy. Staff spoken with told us they felt there were enough staff to meet the needs of the people who used the service and the duty rosters we looked at confirmed there was a consistent level of staff in place to deliver care and support to people who used the service. The registered manager informed us that staff allocated to work in specific tenancies, followed the tenancy duty rota which was compiled according to the support needs and level of dependency of people who used the service and the specific skills of the staff. This meant staffing levels varied in different tenancies. Staff worked closely with people to assist them to meet their specific needs and provide a consistent response to those needs. A relative of a person who used the service said about the staffing levels, "There is always enough staff for [relative] to do the things he likes to do."

We spoke with two support workers who described their recruitment process. Both support workers confirmed after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered manager carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. We saw evidence that support workers were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to

be satisfactory. Staff records showed where issues of poor practice was raised they had been addressed appropriately through the whistleblowing and disciplinary procedures.

A medicines policy was in place that ensured the safekeeping and administration of medicines that was followed, monitored and reviewed annually. All staff had been trained in the safe handling of medicines. The registered manager told us medicines were stored in a locked cupboard, which was confirmed when we visited a tenancy. In the tenancy we visited we saw a list of authorised medicine handlers [support workers] had been signed and kept up to date. Support workers were not able to administer medicines until they had received appropriate training in this topic. Medicines were provided in individual dosette boxes by the supplying pharmacist. This helped to make sure the correct dose was administered as prescribed.

Support workers spoken with were knowledgeable about the process for checking the right dose according to the GP instruction and administering medicines following the homes medicine administration policy. They had good knowledge of why people required their medicines, the dosage, the desired effect and the action they should take in the presentation of side effects.
We looked at the medicine records for a person and found the records completed were up to date. We asked a person using the service if their medicines were administered on time and they confirmed they were. From the details in some of the domiciliary care records we looked at we saw some people were assisted with their medicines by a family member.

The registered manager told us that people requiring support with their medicines had a Medication Administration Record (MAR) in their care file and their medicines were listed. Support workers signed the MARs to confirm the medicines had been administered and taken by the person. They told us that the same information was recorded in the daily log to inform other Support workers that medicines had been administered according to the person's care plan. A care worker spoken with confirmed they had received appropriate training in medicines awareness and administration and was currently responsible for administering people's medicines. With the agreement of a person using the service we visited them in their home and checked the MARs during the visit. The person confirmed their medicines had been administered correctly and when we examined the MARs we saw they had been signed by the care worker on duty. Some people who used the service required medicines as part of an intervention strategy, for example to control frequency and severity of epileptic seizures. This is sometimes referred to as 'rescue medication'. We saw that where this was the case staff were trained in appropriate procedures to administer this medicine.

Support workers we spoke with told us the registered manager provided them with personal protective equipment such as gloves and aprons which helped to protect them and people using the service from the risk of cross infection whilst delivering care. They were aware of the need to make sure they used the protective equipment available and one care worker said, "There is always plenty of equipment for us to prevent cross infection."

Good

Is the service effective?

Our findings

When we spoke to the people who used the service, they were complimentary about the staff and their ability to provide care and support. One person said, "I like the staff because they help me. Me and [support worker] have a laugh."

New support workers were given a full mandatory induction that covered topics such as, fire evacuation, control of substances hazardous to health (COSHH), role and responsibilities, risk assessments, lone working, organisational policies and procedures, five key questions (is the service safe, effective, caring, responsive and well-led), medicines, good practice, use of hoists, staff supervision and mandatory training in care, health and safety and identified areas for personal development. This was followed by a period working at specific tenancy or under the supervision of an experienced support worker within the community. This gave the new worker the opportunity to get to know the people who use the service. A probationary period of six months could be extended if required. Senior support workers were inducted over four months. Additional induction training was provided via the Care Certificate. This is a professional qualification that aims to equip health and social care staff with the knowledge and skills they need to provide safe and compassionate care.

On going comprehensive staff training was also available in topics such as, safeguarding adults, first aid, medication, food hygiene, history and caused of learning disability, equality and diversity, child protection, understanding behaviour, empathy and empowerment and personal relationships. Clinical subjects such as epilepsy, autism, mental health awareness and positive behaviour management were also included. The registered manager told us that where it was identified staff required training in other areas to meet people's specific needs training would be arranged for all staff. Some people who used the service required medicines as part of an intervention strategy, for example to control epileptic seizures. This is sometimes referred to as rescue or Buccal medication. This medication requires administration via a sublingual route which means when placed under the tongue for rapid absorption by the body. We saw staff training records to show where this was the case staff had been trained in appropriate procedures to administer this medicine. Support workers spoken with said about the training provided, "There's not much training we haven't done. If staff require additional training, it's given and this helps us to support the person to meet their needs better." A relative spoken with said about the staff training, "The staff are very dedicated and a lot is down to staff training."

There was an on going annual staff appraisal and supervision system in place to discuss and evaluate the quality of staff individual performance and where best practice or practice improvement was demonstrated. Staff we spoke with confirmed they received regular supervision and an annual appraisal. Each tenancy had a senior support worker responsible for ensuring all support workers had a supervision session at least four times each year. Records examined showed a clear timetable setting out times and dates for individual support worker supervision sessions. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). 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.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw risk assessments and a service user finance capacity form had been completed when any interventions might be restrictive and these assessments showed that the least restrictive practices had been considered and implemented.

The registered manager and support workers were knowledgeable about any MCA capacity assessments in place for people who required them. Best interest decisions were recorded including any consultation undertaken and a rationale for reaching the decision made. The registered manager told us any applications made to the Court of Protection to provide care and support for people who were unable to make decisions about their care and support would be followed subject to Court of Protection decisions.

We looked at how the service managed challenging behaviour and the restraint of people who used the service. Restraint is an act or condition that keeps someone or something under control or prevents them from doing something they wish to do. We were told that 'Team Teach' training was provided for staff to implement when de-escalation and positive behaviour management was required. Support workers who had completed the training explained that this helped the staff to recognise when individuals may be getting distressed, and to look at more appropriate ways to divert their attention. The training also aims to promote the least intrusive positive handling strategy using graded techniques, with an emphasis and preference for the use of verbal, non-verbal de-escalation strategies being used and exhausted before positive handling strategies are utilised.

The service supported people with varying degrees of support needs ranging from mostly independent to requiring increased levels of support. Some people were able to plan and select their food choices with assistance from support workers. We saw that people had choice about what they wanted to eat. We saw that where possible people were supported to do their own shopping for food and received help to prepare their meals and on examining the care records we saw attention was paid to what people ate and drank. Daily record sheets indicated the type and amount of food people had eaten. This meant people's nutrition and hydration was monitored.

Care records showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, and the notes were included in people's care plans. Where people had been assessed as having a risk associated with eating and drinking, such as choking, people had received specialist assessment and advice from the speech and language therapist (SALT) and the advice was followed. Other care files showed attention was paid to general physical and mental well-being, including health action plan records which recorded people's weight, dental and optical checks, and gender specific annual health checks.

It was apparent from speaking with a person using the service, their relative and examining care records that people were actively involved in making decisions about their care and support and their consent was sought and documented. Support worker we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support and said, "It's vital to support people to make choices in their lives so we can build on them in areas like promoting independence in their cooking or doing their own laundry."

The tenancy we looked at was secure, and team leaders took responsibility for making sure health and safety audits were carried out on a regular basis, including monthly fire drills at each tenancy, and yearly checks on water, gas and electrical appliances. A landlord was responsible for the maintenance of all tenancy properties.

Good

Is the service caring?

Our findings

We saw that the culture of the service was geared to the needs of the people who used the service. Respect and regard for the rights of people who used the service was central to the delivery of care and support, and we observed good interpersonal relationships between staff and people who used the service.
A person's relative said, "They [support workers] respect his [service user] wishes. The staff are outstanding people and are so supportive to the family and they listen to all of us. He's has got his own identity and the support worker is like a brother to him. The service goes beyond what we expected. It's fantastic, I couldn't be happier for him."

Care records examined had been written with concern, empathy and understanding of individual needs. For example a care record we examined described a person's morning routine and gave detailed instructions about how the person should be woken by stating; support me out of bed, assist me with washing, teeth, oral hygiene, dressing and choosing clothes. Do's and don'ts clearly explained what to do and what not to do when delivering the person's care.

Support workers said, "We need to know what to look out for and the best approach, that's why the care plans are so clear. We have to have a consistent approach to the care being given, because it takes a lot of confidence and time to trust us [staff]."

We saw that staff had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect. For example, when we asked to look at a person's care record the support worker first asked the person who used the service for their permission. Staff understood people's particular communication styles and how to interact positively with them. Where people had difficulty communicating staff remained patient and took time to listen, acknowledge what they were saying and respond appropriately. For example, we overheard a general conversation between a person who used the service and a support worker where the support worker listened and was able to explain a particular issue to the person and reassured them matter would be addressed appropriately. The tenancy we visited conveyed an open, relaxed and friendly atmosphere. Conversation between people and staff was respectful and demonstrated a good understanding of the needs and interests of the people who used the service, such as friendly banter about rival Manchester football teams.

Care records showed and we saw people were encouraged to remain as independent as possible, and staff supported people to manage tasks such as personal hygiene and basic cooking within their capabilities. It was apparent that the people who used the service enjoyed the responsibility this afforded.

People who lived in tenancies were well matched, had single bedrooms and shared communal areas such as a lounge, dining room and kitchen. Consideration was given to their compatibility and a relative said, "It's just like he [service user] is at home. He's treated as he would be at home with his family. He and another service user have known each other since childhood. It's lovely that they're able to live together as adults."
The registered manager told us the service placed a high degree of emphasis on compatibility with other service users and support workers before determining suitability to move in to one of the properties or

domiciliary care being provided.

Whilst nobody was using an advocate at the time of the inspection discussion with a senior support worker showed they were aware of how to access advocates for people. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We were told the cultural and religious backgrounds of people were always respected, and when we talked with staff members they were able to demonstrate an understanding of the diverse needs of different cultures or religions. The staff learning and development plan showed equality and diversity training had been completed by most of the staff team and further training in this topic was on going.

We saw that all records and documents were kept securely in the staff offices, and were told that other houses and properties had a staff room were records were stored. This ensured that confidentiality of information was maintained.

The registered manager told us that whilst nobody using the service required end of life care, staff training would always be provided in this topic and the relevant professionals such as district nurse and GP would be involved. Any programme of learning for support workers to develop awareness and knowledge about end of life care would be put in place and an appropriate care and support plan would be implemented to consider how best to meet the person's needs at that time. We looked at a document called, 'Planning for my end of life', which was included in people's care records. The document format was person centred and geared towards helping the person to have as much control as possible about decisions relating to future care and end of life needs. The document also made reference to what mattered to the person's family and friends.

Good

Is the service responsive?

Our findings

People who used the service and their relatives told us that the service was responsive and met their needs. One relative said "The support workers are absolutely dedicated. They have the right personality. They respect his [service user] wishes."

The registered manager told us that detailed assessments were undertaken by a senior member of staff before a person began to use both the domiciliary service or moved into a supported tenancy. Following the initial assessment a comprehensive assessment would be completed and plans put in place to make sure people could be supported by the right support worker. Consideration of social skills and interactions was given a high priority along with physical and mental health needs, and we saw evidence in the form of detailed care plans that had been drawn up to support the next stage of intervention.

We looked at four care records which contained comprehensive information about each person and sufficient detail to guide staff on the care and support to be provided. Care records included the person's emergency contact details such as their next of kin, and GP, risk assessments, current support needs, the support to be provided and the desired outcome from the care and support provided. They contained relevant information about people's diagnosis and associated needs, community needs, leisure and communication.

Detailed instructions were provided to support the person with specific tasks, such as 'eating and drinking' or 'managing their finances' broken down into specific tasks. Care plans were written in a person centred way and demonstrated a good understanding of the person. For example, in one care plan we looked at there was information about the person's epilepsy and how it presented. It stated the type of seizure, the seizure behaviour and appearance staff should recognise, the frequency and typical duration of the seizure and what staff should do when the person experience a seizure.

All care records contained a recent photograph of the person, information about 'what I like to do', likes and dislikes, things important to me, day and night routines, weekend activities and hopes and dreams. Where people's support needs were identified as requiring two staff, the reasons why were clearly documented. Specialist information and guidance from the relevant professionals involved in their care, such as physiotherapists, was also contained within the care records.

We examined additional care plans from people's supporting networks such as schools and educational services which were included in the care records of younger adults who used the domiciliary care service. These supporting records helped to make sure the service had current information about the person that would help to fully meet their identified needs.

A daily support session log sheet clearly detailed the support provided at each activity session. Support workers were required to record what they had learned, what did and didn't happen, what worked well, what the person liked and disliked, the action that needed to stay the same and what needed to be done differently moving forward. We looked at incident forms completed following an incident where risk was

apparent. Care record daily log sheets provided a high level of detail and where risks to people's health and wellbeing had been identified support workers recorded the action they would need to take to reduce or eliminate any identified risk.

Support workers were aware of the importance of the care plan review system. They told us any information about the person was reviewed to make sure it fully reflected the person's current support needs, and when any changes were made all staff were made aware of the changes to reduce the risk of improper care being provided.

Person centred reviews were held every six months or sooner where required or requested and involved the person who used the service where they had the capacity to be involved in the planning of their care. Family members or advocates, the person's support worker and their social worker, teaching support worker and other appropriate professionals would also attend the review meeting. Where issues were identified this was noted and follow up action was recorded.

The service was flexible in its routine where people who used the service would normally attend further education classes during the term time. Extra staff were available during school holiday periods to ensure continuity of care and access to leisure pursuits was maintained for those people. People were encouraged to take part in activities and supported to find meaningful occupation. Where possible people who used the service were supported to find employment or training and some people who used the service had access to day services in the community. People were supported to continue taking part in their hobbies and interests or seek new pursuits and this information was recorded in their care records. Individual and group activity plans for people who used the service were kept in people's individual care records and included different daily leisure and learning activities.

A complaints policy was in place and we looked at how the service managed complaints. The registered manager told us that complaints were addressed following the services complaints procedure. Complaints were logged and allocated to a senior member of staff to investigate. These would be monitored by the HR director and records kept of actions taken. The service kept a computerised log of any complaints made and the action taken to resolve the issues. We examined the services complaints log and found any complaints made had been
resolved to the satisfaction of the complainants. We were satisfied that the policy in place allowed for a full investigation and all complaints were taken seriously. The policy allows complaints to be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome. Where possible, action was taken from complaints to improve the quality of service delivery. The registered manager recognised that not all complaints could be dealt with satisfactorily and accepted that positive criticism was a useful way to ensure a good standard of care was maintained. A relative spoken with told us they were of how to make a complaint and said, "I have never needed to complain about the service but would initially speak to the support workers if I needed to."

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Community Housing and Related Support is registered with the Care Quality Commission (CQC). When we visited, a registered manager was in place as required under the conditions of their registration with the CQC. The registered manager was registered with CQC on 22 August 2016 and was present during the inspection.

The registered manager, senior managers and staff members, understood their role and responsibility to the people who used the service and demonstrated their commitment to the company by having clear visions and values about the service. The registered manager told us they wanted to make sure people who used the service had as much control and choice as possible about the service they received. They told us that a person centred approach was designed to help people achieve their desired outcomes based on what was important to them. This made sure the service provided high quality support to people who used the service.

The service was in the process of developing and reorganising the way in which it was managed. The current registered manager had responsibility for the domiciliary care service and the supported tenancy scheme. However due to the business growth and service demand, the provider had submitted an application for another person to be registered as manager for the domiciliary care service. The proposed registered manager was already in post and was fully involved in implementing any changes to ensure there was no disruption to the care provided to people during the management transition.

Part of the organisational mission statement stated, "Independent Options seeks to contribute the building of a competent community that will include every person, regardless of their additional needs in everyday life. This was achieved by providing a range of opportunities for people with disabilities or mental health needs to spend valued time away from their families and providing appropriate support to individuals within their own communities to build their skills and increase personal competencies. Partnership work and contributing to research projects helped the provider to further their knowledge to provide the best services possible for people.

There was a clear management structure in place and staff spoke positively about the registered manager and the team. They told us they enjoyed their work and thought management responded well to the needs of staff and of the people who used the service. Staff spoken with said, "We work as a team, because it's vital to support people to promote their independence. People trust us to look after them and that takes confidence." Staff knew what was expected of them and understood their role in ensuring people received the support they required and their responsibility to provide this in a caring way.

Meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about the service but also what, if any, improvements could be made. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution.

We examined systems in place to monitor the quality of the service to ensure people received safe, effective and responsive care. We saw regular audits/checks were undertaken on all aspects of the running of the service and team managers would regularly review the service delivery at each of the tenancies and within the domiciliary service. We saw evidence of recent audits on reporting systems, accident and incident reporting, people's risk assessments and environmental risk assessments at different tenancies which included checks on floors, stairs, lighting and windows. These showed where improvements were needed, the landlord responsibilities and what action had been taken to address any identified issues.

Accidents and incidents were recorded and had been regularly monitored by an internal health and safety team to ensure any trends were identified and addressed. We were told that there had been no identifiable patterns in the last 12 months. Similarly, any safeguarding alerts were recorded and checked for any patterns which might emerge.

The registered manager provided us with copies of the services policies and procedures such as, complaints and suggestions, safeguarding adults and children, accidents and incidents, medicines, staff recruitment and whistle blowing. All of the policies we looked at had been reviewed regularly with the next policy review date being February 2017. A business contingency plan was in place which identified the provider actions when an exceptional risk though unlikely, would have catastrophic consequences to people who used the service and staff.

We examined the notes from the monthly community managers meeting, and community support worker team meetings, which showed topics such as service user groups, service user assessments, good practice guidelines, CQC and service user updates were discussed and actioned.

A quality assurance system was in place to help the provider find out and respond to the needs of people who used the service, relatives and representatives and stakeholders. The human resources director told us the system provided service consistency to the required standards and this was evidenced through having well trained, motivated staff, good management systems, meaningful user involvement, good financial systems and positive inter agency working.

The provider used a practical quality assurance system for small organisations (PQASSO) to implement continuous improvement within the workplace. PQASSO addressed the following 12 points, planning for equality, governance, management, user centred service, staff and volunteers, training and development, managing money, managing resources, managing activities, networking and partnership, monitoring and evaluating and results. The human resources director monitored and completed the system when relevant information was submitted to provide a business overview. Any action identified was addressed and implemented as required.

We examined the community support team good practice guidelines which identified five essential accomplishments such as, community presence, community participation, encouraging valued social roles, promoting choice and supporting contribution. These points helped to monitor and evaluate where people who used the service had moved towards positive daily experiences.

The provider was awarded the Investors In People (IIP) silver award which showed the organisation had exceptional resilience in their approach to planning. Learning and development was found to be robust and a major strength. Staff were identified as being talented and skilled with good and effective leadership. Through this award, provider continuous improvement was evident over the three years since receiving the award. Investors In People is the standard for people management. The standard defines what it takes to lead, support and manage people for sustained business success.

The registered manager told us the service annual review and the results of service user satisfaction questionnaire had not yet been evaluated and finalised. However once completed CQC would receive copies of both records. We examined the results of the annual staff survey where staff had made positive comments about their experience of working for the organisation. One comment stated, "I would recommend Independent Options (IO) to anyone in need of a caring environment for a family member to live, stay or move to as it is a good organisation who cares for clients well."

We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.