EMH Care and Support Limited

EMH Supported Living

Inspection report

Ellen House, Heath Road
Holmewood
Chesterfield
Derbyshire
S42 5RB

Tel: 01246599999
Website: www.emhcareandsupport.org.uk

Date of inspection visit:
12 February 2018
13 February 2018
14 February 2018

Date of publication:
24 April 2018

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This service provides personal care and support to people living with learning disabilities, including some with physical disabilities. At the time of our inspection there were 105 people using the service across shared supported living settings located within North Derbyshire and North Nottinghamshire. This enables people to live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service is run from an office in the village of Holmewood, north east from Chesterfield town centre. We carried out this inspection on the 12, 13 and 14 February 2018. We visited the provider's office on the 14 February 2018. The provider was given four working days' notice of our inspection to arrange and seek people's permission for us to speak with them in their own homes on 12 February and to speak with some people's relatives by telephone on 13 February 2018.

There was a registered manager for the service. 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 personal have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in October 2016, people who used the service were not protected from risks associated with ineffective monitoring and evaluation of the service. We asked the provider to complete an action plan to show what they would do and by when to improve the service. This was because the provider needed to improve the key question about how they ensure the service is well led in relation to its management, governance and oversight; to at least good. This is the second time the service has been rated as Requires Improvement.

Required care and service improvements had not always been proactive, timely or sustained. Revised service planning, management, communication and quality monitoring systems were introduced to reduce any related risks to people from this. Further improvement was required to fully ensure people received consistent and effective care with timely and sustained improvement when required.

Action was taken by the provider in consultation with the local authority to address recent safeguarding concerns relating to the safety and effectiveness of people's care, medicines and monies at the services. Subsequent improvements to related safety and staffing systems showed lessons learned learnt from this to ensure people's safety.

People felt safe at the service and relatives felt they now received safe care. Recognised staff recruitment procedures were followed for people's safety.

Staff understood risks to people's safety from their health conditions, equipment or environment and their

related care requirements. Revised care planning, incident reporting and related management monitoring and analysis helped to further ensure people received safe, consistent and least restrictive care.

People were protected from harm and abuse; both they and their relatives were informed and confident to report any concerns if they needed to. Staff knew how to recognise and report the suspected or witnessed abuse of any person receiving care at the service.

Safe working systems were monitored and ensured for the prevention and control of infection, any equipment used for people's care and for emergency contingency planning.

Staff had not always obtained people's consent or appropriate authorisation for their care and people had not always received consistent care in their best interests. Management improvement actions were in progress to address this where required.

Overall, people were supported to maintain their health and nutrition and to obtain and use any care equipment they needed. This was done in consultation with relevant external health professionals when required.

Staff training, supervision and competency measures had not always been timely or consistent to accurately inform people's care. Management action was in progress helped to fully ensure this.

Staff were kind, caring and respectful. The provider's recent introduction of nationally recognised voluntary care standards associated with supported living, helped staff to further understand and promote people's choice and rights to live they life they choose.

People and relatives were regularly consulted and informed about the care they could expect to receive from the service. People were provided with a range of service information and for their shared care when required. This included a range of suitable methods and information formats to help people understand and as agreed with them.

People received timely, individualised care from staff who knew how to communicate with them. People were regularly supported to engage with friends, family and in occupational and leisure activities they chose.

People and relatives were informed and confident to make a complaint or raise any concerns they may have about their care. These were accounted for and used to help inform any care and service improvements needed.

People, relatives and staff were more confident in the management of the service. The registered manager and senior management were visible, approachable and listened to their views.

Staff understood their role and responsibilities for people's care and they were confident, supported and knew how to raise any related concerns. Comprehensive and regularly reviewed operational care, safety and staff policy measures helped to support and inform this. The provider had usually notified us of important events that happened at the service when required. They acted to fully ensure this when we asked them to following one notification oversight on their part.

The provider ensured safe, lawful information handling and data management systems concerned with people's personal information and also for staff employed. Introduction of a comprehensive electronic

record keeping and staff communication system was in progress to ensure timely, secure and consistent access to relevant care and management information sharing across the service.

A range of mechanisms were regularly used to consult with, inform and engage people, relatives, staff and external professionals with an interest in people's care at the service to help inform and drive service changes and improvements.

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.

Prompt action was taken when required to ensure people's safety at the service following safeguarding concerns raised. Subsequent systems improvements showed people's medicines and personal monies were safely managed where required. People were supported safely by staff who were effectively recruited and deployed. Staff understood people's overall safety needs and their related care requirements. People, relatives and staff were confident and informed to raise any concerns about people's care and safety

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act (MCA) 2005 was not always followed to ensure people's consent or appropriate authorisation for their care. People had not always received consistent care in their best interests. Management improvement actions were in progress to address this where required. Staff training and supervision provision had not always been timely or consistent to inform people's care. Related management improvements were in progress to fully ensure this. Staff supported people to maintain and improve their health and nutrition in consultation with external health professionals when required.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and respectful. The provider arrangements for people's care helped to ensure their dignity, choice, independence and rights to control their lives. People and relatives were regularly consulted, appropriately informed and understood the care they could expect from the service.

Is the service responsive?

Good

The service was responsive.

People received timely, individualised care from staff who knew how to communicate with them. People were regularly supported to engage and participate in their daily living, social and lifestyle activities of their choice. People's and relatives views about the service were regularly sought and they were confident and knew how to make a complaint if they needed to. Findings from this were used to help inform and improve people's care when required.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Management improvements needed at our last inspection for the consistent monitoring, evaluation and record keeping in relation to people's care were not fully completed. Further improvements were in progress to help ensure this but the provider needed to demonstrate ongoing and sustained service improvement. People, relatives and staff were more confident in the management of the service. Management regularly sought to engage with people, staff and others with an interest in the service to help inform and drive service changes and improvements needed

EMH Supported Living

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.

Before our inspection the local authority shared information with us relating to safeguarding concerns they found at the service, which they had investigated with the provider. This found where improvements were needed for people's care and safety. From this, the provider had produced an agreed action plan to demonstrate how this would be achieved.

The provider sent us their Provider Information Return (PIR) and notifications about important events that happened at the service when required. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also received completed care questionnaire surveys from nine staff, two people receiving care and three external health and social care professionals concerned with people's care at the service. This helped to inform us about people's care experience and staffs' working arrangements with this provider.

This inspection was carried out on the 12, 13 and 14 February 2018 by three inspectors. We visited the provider's office on the 14 February 2018. The provider was given four working days' notice of our inspection; to seek people's permission or check their best interests when required, for us to visit some of them in their own homes on 12 February and also to speak with some people's relatives by telephone on 13 February 2018. At the time of our inspection there were 105 people receiving care from the service.

We observed how staff interacted with people who used the service. We spoke with six people who used the service and six people's relatives. We spoke with twelve care staff, including two care co-ordinators; three assistant area managers, the registered manager, an inclusion officer and the provider's inclusion and engagement officer and their quality and compliance, complaints and safeguarding management staff leads. We also spoke with local care commissioners concerned with people's care at the service. We looked

at eight people's care records and other records relating to the management of the service. This included medicines, staffing, complaints and safeguarding records and the provider's checks of quality, safety and their related service improvement plans. We did this to gain people's views about their care and to check that standards of care were being met.

Good

Is the service safe?

Our findings

The provider had acted to address safeguarding concerns in consultation with the local authority and was able to demonstrate improvements made and in progress. This included review of medicines safety and staffing arrangements; communication and incident reporting and for positive behaviour measures. Records showed the provider's ongoing management monitoring arrangements for this to help ensure people's safety. A staff team leader role was also introduced into one of the shared living houses where the safeguarding concerns had been found; for increased oversight and leadership. This showed lessons learned and helped to ensure improvements for people's care and safety.

Since our last inspection, the provider had revised their staffing structure and deployment arrangements. Due to staff changes during this time, people had not always received care from staff who knew them well. However, staff restructuring was almost completed. New and vacant posts were recruited to across the service with a significant reduction in the use of agency staff. Some staff offers of employment were subject to completion of relevant employment checks. This included checks with the governments' national vetting and barring scheme (DBS). The DBS helps employers to make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups of adults or children.

People and relatives said people were safe when they received care from staff. One person said, "Yes; staff are pretty good here." A relative said, "Yes it's safe; there have been a few staffing related problems – it's important to have consistent staff who understand people; with new staff it takes a while; but it's improving and settling now."

Staffing was sufficient and recently improved. One care staff said, "We are very flexible to cover for absence when needed; it's better for people to have staff they know to provide their care; If we need agency, management try to ensure consistency of staff for people. Another told us, "Having new staff has been really good; and it's a diverse staff group now." This showed the provider had acted to ensure sufficient, safe and consistent staffing provision for people's care

From recent safeguarding investigations, the provider found staff had not always acted in a timely manner to report any related changes or safety incidents when required. This meant some people had not always received care that was timely, consistent or helpful to them such as positive behavioural support. Revised incident reporting procedures were introduced for staff to follow along with related training and incident analysis and monitoring. Related records showed a subsequent improvement in the consistency and timeliness of reporting by staff. This helped to inform any changes needed to people's care for their safe, consistent support when required. For example, provision of additional care staff for one person's positive behavioural support helped to ensure the person received safe, consistent and least restrictive care in a way that was helpful to them. Staff received appropriate training to enable them to provide people with safe positive behavioural support when required. This included nationally accredited training on behaviours in learning disabilities (BILD). This helped to ensure people received safe, consistent care in the least restrictive way and in a manner that was helpful to them.

Following recent safeguarding concerns, the provider had acted to ensure people's medicines and personal monies were safely stored and recorded. Revised ongoing management checks were introduced to ensure this was consistently done. Related management action included, medicines systems and policy review, staff instruction and retraining. People received their medicines when they needed them. Care staff knew how to support people with their medicines safely and helped them to understand what their medicines were for. This included supporting people who wished to manage their own medicines and were risk assessed as safe to do so. One care staff told us, "We have had more medicines training as we'd had administration problems; so we couldn't give medicines until we'd had the training."

Staff understood risks to people's safety associated with their health conditions, equipment or environment. They also understood related care requirements to follow to reduce any risks identified. This included where people were at risk of infection. Relevant systems and training were in place for the prevention and control of infection. Staff were provided with personal protective clothing to use when required for people's personal care such as disposable gloves. This helped to ensure people's safety.

People, relatives and staff were confident and supported to raise any concerns they may have about people's safety. Revised guidance was recently introduced for people in an easy read and pictorial format to help them recognise and report abuse. Staff knew how to recognise and report the witnessed or suspected harm or abuse of any person receiving care. The provider's staff whistleblowing procedure supported staff to do this. Whistleblowing is when a person exposed any kind of information or activity that is illegal, unethical or not correct within an organisation, either private or public.

Staff were provided with guidance to follow for people's safety and safe working systems. For example, staff lone working or in the event of adverse weather conditions. There was a recognised system for staff to access senior management outside of normal working hours when required. One person told us they and a staff member checked the fire alarm system each week to make sure it was working properly. The registered manager told us about their improvements to ensure consistent fire alarm testing, fire drills and the timely maintenance and repair of their own shared living accommodation where some people received personal care.

Requires Improvement

Is the service effective?

Our findings

Before our inspection local authority safeguarding investigations in consultation with the provider found people's care plan records were not always sufficiently detailed to accurately inform people's care. This included people's mental capacity to consent to their care; care that needed to be provided in people's best interests and for people's positive behaviour support. Relevant information from external health professionals and relatives concerned with people's care was also not consistently reflected.

We checked whether the provider was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff received training in the MCA but had not always understood or followed this in people's best interests. People's care plan records had not consistently shown how people's consent was obtained, authorised or in their best interests, which meant there was an increased risk from this of people receiving inconsistent or inappropriate care. Management improvements were identified to help reduce the risk with timescales for completion. This included the planned introduction of a recently revised and standardised approach to people's related assessment and care planning needs across the service; along with staff guidance and training measures. However, there was still a risk of people receiving inappropriate care without their consent or not be in their best interests until this was completed.

Some people's freedom was being restricted a way that was necessary to keep them safe and in their best interests. For example, by their continuous supervision from staff when out in the local community. Appropriate action to seek formal authorisation for this (DoLS) had been sought from the relevant local authorities concerned with this. One person told us about a care restriction to their freedom, which they said they had agreed to but were unhappy about. There was no relevant assessment or care plan to show how or whether the restriction was lawful or in their best interests. We discussed this with the registered manager who has told us since our inspection about their action to address this to ensure consistent, lawful and effective care.

Where people were considered to have capacity they were supported to manage their own monies. One person's affairs were managed and controlled through the Court of Protection. Two people had deputies appointed by the Court of Protection with powers to make decisions about the service provided. The Court of Protection makes decisions and appoints 'deputies' to act on behalf of people in their best interests if circumstances require when people are unable to make important decisions about their finances or health and welfare. Decisions made through the Court of Protection were followed. One person had appointed a

relative as lasting power of attorney to act on their behalf to make important decisions about the service. Staff understood the arrangements, which helped to ensure people's rights and best interests in their care.

Staff often received training and supervision they needed to perform their role and responsibilities for people's care. However, the provider's staff survey conducted in November 2017 showed that more than 20 percent of staff did not feel fully supported to access training and qualifications to progress. The provider's staff training record showed some gaps in staff training, mainly attributed to either overdue refresher training or new staff employed with training pending. Training was planned to address this along with management improvements to ensure staff received regular supervision and instruction for their role where required. For example, in relation to revised care planning systems, positive behaviour support and supported living principles. One care staff member said, "Behavioural and support plans are being developed; its work in progress so not completed yet; We've started reviewing care plans in this way with people; we look at so much more now."

Staff training was regularly provided, specific to people's individual learning disabilities, physical health conditions and related personal care needs. Relevant staff knowledge and competency checks were undertaken before staff provided people's care. Staff were also supported to achieve recognised national vocational qualifications concerned with people's care.

One care staff member said, "The training is good; you come back with real knowledge and put it in place; it really makes a difference. Another care staff told us, "Training is brilliant and always available. Another said, "The group have been really supportive; I have dyslexia; they make sure I have all the support I need with training and doing NVQs (national vocational qualifications). A recently employed care staff described their suitable role induction and related training to enable them to provide people's personal care. This included shadowing a more senior care staff member and completion of the care certificate, which was introduced for all new staff to complete. The care certificate identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

People were supported to maintain and improve their health and nutrition. This included support to attend appointments with external health professionals when required for the purposes of routine and specialist health screening, advice and treatment and also for their sexual health. Care referrals were made to external health professionals when required. Referrals to speech and language or clinical psychology professionals were further established for people's communication needs, to accurately inform their care. For example, to help staff to understand what was important to people for their care and what was helpful or unhelpful to them for their positive behaviour support.

Some people were supported by staff to plan, shop and cook their meals as required; others did so independently. One person said, "When I am at home I make my own lunch, like spaghetti hoops on toast and I make my own hot drinks when I want them!" Another told us, "On a Sunday we have a roast; The rest of the week it depends on who is on – maybe microwave meal or pasta; We all give £45 each and the shopping is done." Another person living in shared supported living accommodation said, "We sit together and make a menu each week so we can do a shopping list; We do all the shopping; we take it in turns doing the cooking and we cook for each other."

Some people had specialist dietary requirements for their nutrition, instructed by external health professionals, which staff understood and followed. For example, specified food consistencies, such as soft, fork mashed or blended meals were provided where required for people with swallowing difficulties, to

enable them to eat their meals safely. A relative said, "They [person receiving care] has blended meals because of swallowing problems; meals are beautifully presented, healthy meals and there's always choice." This helped to ensure people received adequate nutrition.

Good

Is the service caring?

Our findings

People received care from staff who were kind, caring and supported their dignity and rights in care. One person said, "They [staff] are very good; they don't shout; they advise." Another said, "Staff are good at supporting you, which is what we need because it's supported living." Another said, "I have a key to my room; staff don't go in without asking me first." A relative said, "Staff are caring, kind and promote dignity; I don't think you could get any better."

We received positive comments from people and relatives, which showed people's choice, inclusion and independence was promoted. For example, one person said, "I am very happy here; I have my own independence and I like doing what I want when I want; I can have friends here whenever I want to." A relative told us, "Staff have marvellous care principles; they know [person receiving care] really well." People and relatives felt they had good relationships with staff. A care staff member said, "People we support are like our extended family."

People were informed, consulted and involved in agreeing their care. One person said, "I came and looked round here and one other place; I met other people living here; one person showed me round and I came for tea." This helped the person decide whether they were happy to move into their shared supported living accommodation. Some people were involved in interviewing and choosing staff to support their one to one care when needed. The registered manager told us about plans to extend this to involve people in all care staff recruitment interviews; to ensure people had opportunity to meet with prospective staff wherever possible to help decide if people were happy for them to provide their care.

People's care plans were agreed with them. The provider's recently revised care planning system helped to further the personalisation of people's care plans. One staff said, "We've just started reviewing the care plans; we look at so much more now; We've found out that some of the things in there just weren't right. We used to just do it ourselves – it's much better now."

The provider used a range of methods to help inform and consult people about their care. Individual meetings; shared living meetings and service forums were regularly held with people. A regular service forum was also held for people's relatives. Recorded minutes from this were provided for people in an 'easy read' large print and pictorial format to aid people's understanding. Further information, to help people understand the law and their rights in relation to their care for consent and decision making was recently developed and ready for circulation. People were informed and supported to self-advocate and access independent advocacy services, if they needed someone to speak up on their behalf about their care. This had recently helped one person achieve a positive outcome by enabling their control and autonomous decision making in relation to key aspects of their life. Each person had a 'hospital passport,' which showed their known care preferences, communication needs and how they wished to receive their care and treatment. This was provided and went with the person if they needed to be admitted to hospital. This helped to inform people's care in a way that was helpful to them and which they had agreed.

The provider had recently introduced a set of nationally recognised voluntary care standards for supported

living. The standards aim to ensure each person is able to live the life they choose with the same choices, rights and responsibilities as other citizens. A care staff member said, "It's important, we are here for the people we care for; what they want; where they choose to go and how they want to live." A relative said, "They [staff] know people's choices; in the past they had fallen into their own routines that were helpful to them but not always the person's choice; they know what needs to be done now – it's on track; they are starting to really understand the principles of supported living." This showed the service was caring.

Good

Is the service responsive?

Our findings

People received timely care, individualised care. One person said, "Staff helped me to move to an upstairs room to help me sleep when I asked; they swapped over the staff sleepover room." Staff engaged with external health professionals in a timely manner following any sudden changes in people's health. For example, a relative described how staff acted promptly following a sudden change in one person's health condition and said, "Staff were prompt to get the doctor, which resulted in a medicines change; It was all dealt with very smoothly."

Staff knew how to communicate with people. For example, by verbal language or by use of hand, facial gestures or visual aids, such as picture cards; or recognised sign language such as British sign language or Makaton. Makaton helps hearing people with learning or communication difficulties through the use of signs and symbols with speech, in spoken word order. British sign language is the language of our deaf community. It has its own grammar and word order with regional variations. Peoples chosen method of communication was shown in their written care profile, known as their 'communication passport.' A copy of people's communication passport was kept with the person.

People and relatives felt staff took account of people's views and wishes for their care. Staff understood people's wishes, known daily living routines and lifestyles preferences for their personal and health care requirements. A relative said, "They [person receiving care] enjoy their life; they go out and about and are supported to do the things they want to do and when." A care staff member told us about one person who they supported in a shared living accommodation and said, "They [person receiving care] has a friend from college; they go out on activities together; it's great to have friends; people don't want to do everything together with the people they live with; they can do things individually."

People's care and support needs were assessed before they were received care from the service. This included consideration of people's likely compatibility with others who were living at their proposed shared living property. Varying visits to meet existing residents and for overnight stays helped prepare for any new person moving in.

People were happy and chose where they lived in shared living accommodation. We saw people had their own rooms and personal space. One person showed us their bedroom and own lounge and said, "I like to spend time up here on my own." Another person had their own sensory equipment, which staff supported them to use for their wellbeing and relaxation when required.

People were supported to engage and participate in social, lifestyle and occupational activities of their choice. One person said, "I have one to one staff; sometimes I like to go bowling but today I am going out for lunch; I also go to day service three days a week where I can do differed things; I like wood work and have started a computer course." The person showed us their related certificates of achievement from this. Another person told us, "I go to the shops on my own; staff are taking me out today to help buy art things." Another person regularly went out to work at a local charity shop, which they enjoyed.

People were involved in a range of leisure pursuits such as swimming, bowling, going to the cinema or football matches and meeting up with family and friends of their choice. Some people were supported to attended day centres where they met with others who had similar interests to themselves and participated in activities they enjoyed there, such as art, cookery and sensory activities. People could access a range of support groups, such as living with autism and a women's group. There were plans to extend access to this to other people living in the local community who may also benefit, which existing group members had requested. Staff encouraged and promoted people's independence and supported them to try new things such as sailing or holiday travel and outings. Staff said, "Whatever it is, going on a cruise or an aeroplane, learning to cook – that's why we are here; to help people achieve the life they deserve." Staff told us how they were supporting one person to help increase their confidence and knowledge to travel independently to their chosen day service activity in the local community. Staff said, "Sometimes, it's a compromise; we discuss it and work it out what we need to do together." This showed people were supported to participate and engage with others in the local and extended community; to take part in activities they enjoyed.

People and relatives knew how to make a complaint, or raise any concerns they may have about the service if they needed to. The provider's complaints handling procedure and regular consultation with people and relatives helped to inform this process. Several people said they would always speak to care staff first to try to resolve matters. Three people told us about when they had raised complaints or concerns, which were dealt with promptly to their satisfaction. Complaints records were maintained, which showed the reason for any complaint, their related investigation and any service changes or improvements made as a result.

There were thirty three complaints received about the service during the last 12 months. Complaints were monitored and analysed for themes and patterns to help inform care and service improvements required. Themes were found which related to communication and the quality and consistency of care. Related records showed these were investigated and acted on within reasonable timescales, with improvements either made or in progress.

We did not inspect end of life care as this was not being provided at this inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2016, we found a breach of Regulation 17 of the Health and Social Care Act (regulated activities) Regulations 2014. This was because people were not protected from risks associated with ineffective monitoring and evaluation of the service and inconsistent record keeping. There was also no registered manager for the service at that time. Following our last inspection, the provider sent us their action plan to tell us about the improvements they were going to make to address this and by when. At this inspection we found care and service improvements were either made or in progress, sufficient to rectify the breach.

Service improvements had not always been proactively identified to ensure consistently safe and effective care, which meant further improvement was needed to fully demonstrate continuous and sustained service improvement. Revised management monitoring, communication, reporting and care plan record keeping systems were either established or in progress, along with a targeted and measured service improvement plan to help ensure this.

Following recent safeguarding investigations, service improvements were introduced following concerns about people's safety at the service. This included revised systems for incident monitoring and analysis to consistently inform the quality and safety people's care. For example, in relation to health, behaviour related and safeguarding incidents; concerns and complaints. Related care improvements either made, in progress or assured from this included revised care plan systems, communication and reporting procedures and for the safe storage of people's medicines and personal monies. Additional staff training and staff supervision measures to support this were in progress. The provider's related and ongoing service improvement plan was targeted, measured and kept under regular review. This showed timescales for completion and who was responsible

There was a registered manager for the service. Following the provider's management and staff restructuring across the service, management posts were fully recruited to for care, quality and compliance, safeguarding and complaints and engagement leads. This helped to ensure consistent leadership and management of people's care across the service.

People, relatives and staff said they now felt more confident in the management of the service and found the management to be visible, approachable and listened to their views. A relative said, "It was difficult at first; with all the staffing and management changes but it's all starting to settle down; there's trust building and a positive culture change; it's slowly moving forward for the better." Another said, "Staff and managers good; care is becoming a lot more person centred now." A staff member said, "It's an improved service; people and staff are supported; If you look after staff they make sure people are well supported.

The provider ensured safe and lawful information handling and data management systems. Confidential personal information about people and staff was stored safely and securely. Introduction of an electronic information and technology (IT) system had commenced for more timely and consistent shared care information, communication and reporting. Supporting IT equipment was recently sourced for care staff to

use across the service following relevant training and with a link to the existing management on call system. This provided staff with access to management support for care and safety advice, incident reporting and handling when required outside normal working hours. Record keeping improvements in progress included the streamlining of people's care plans with coded archiving of old 'inactive' care records that were no longer in use.

A range of other operational measures were in place or recently revised and introduced to inform and support staff to carry out their role and responsibilities. This included staff performance and development measures, routine communication and reporting procedures and comprehensive personnel, care and safety policy guidance for staff to follow. For example, in relation to staff conduct; incident reporting, safe care practice, concerns or serious incidents. The provider had also introduced policy guidance for staff in relation to their duty of candour, which staff had signed to say they had read and understood. Duty of candour means staff must be open and honest about all aspects of people's care and treatment, including when things go wrong or any mistakes have occurred.

The provider usually sent us written notifications to tell us about important events when they happened at the service, such as safeguarding concerns. The provider had not notified us of name changes to their service, location and contact details when required. The provider explained this was an oversight on their part and subsequently sent this to us when we asked them to.

Staff we spoke with understood their role and responsibilities for people's care. They were confident and knew how to raise any concerns they may have about people's care or report any related changes or incidents. One care staff member said, "There's more certainty about the company and care we need to provide; it's much better now – we are finding our feet and running with it." Another said, "We have a duty of care: to make sure of people's best interests."

Staff felt they were receiving the management support they needed for their role and said regular meetings were held with them. One staff member told us, "There's always support, twenty four hours a day; I've rung management at four in the morning before and got all the support needed." Another staff member said, "We know we have to provide care in line with policies and procedures; I have followed the whistleblowing procedure before; I knew what I needed to do and got all the support I needed."

Management records showed a proactive approach was taken to create a positive care culture, which included staff instruction, support and training. Formal staff performance monitoring measures were introduced and staff disciplinary procedures were followed where required. Introduction of nationally recognised and voluntary standards for supported living was also in progress for staff to follow for people's care. A relative said, "It's a culture thing; understanding supported living principles; I am confident management are addressing issues to improve."

The provider used a range of methods to consult with people, relatives and staff about the service. A relative said, "There was a time when staff wanted to shut relatives out, but that has changed; we now have staff who are all approachable right up to the top. Relationships are trust building again.

People's, relatives' and staffs' views were regularly sought from individual or group consultation meetings held with them. Care questionnaire surveys were also developed for use. Regular service forum meetings were also held with people and also with their carer's and relatives. These were documented and shared with people in an accessible format, to help them understand. One person was identified champion for accessible information provision. This person checked the forum meeting minutes before they were circulated to people; to make sure they were provided in the most accessible way for them to understand.

The meeting minutes included any service improvements agreed from people's views shared and their implementation. This helped to ensure people's autonomy and control over their care and daily lives.

Recent examples of service improvements from people's views included, increased support to access financial benefit entitlement advice; provision of the provider's key contacts information for people at their shared living properties, such as for maintenance issues. Provision of full time reception cover and provider telephone contact was also established for people at the provider's main office at Ellen House to aid people's direct contact when needed. Systems improvements either made or in progress from the provider's staff survey results in November 2017 related to staff support systems and working terms and conditions; communication systems and team work.