Relativeto Limited

Lowry House

Inspection report

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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

We carried out this inspection on 3 and 4 May 3017 and the first day of the inspection was unannounced. This was the first inspection of this service.

Cambian Lowry House is a purpose built facility and consisted of self-contained apartments providing accommodation for 12 people. The apartments provided single occupancy, or two or three bed facilities. The home had spacious communal areas, activity rooms, a physical fitness suite and an enclosed garden. The home is registered to provide residential care and accommodation and at the time of this inspection there were a total of nine people using the service.

At the time of our inspection a registered manager was in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in the home told us they were happy with their care and liked the staff that supported them and felt safe when care and support was being delivered.

Staff knew how to act to keep people safe and free from harm. The registered manager and senior staff ensured that the building and equipment were well maintained and that the environment had been designed to keep people as safe as possible.

There were enough staff to meet the needs of people using the service. Some of those needs were complex and staff told us they were trained and received appropriate support and supervision to effectively meet people's complex needs. Staff received a full and detailed induction before they started working with people. Induction training was taking place with seven newly employed staff at the time of our inspection.

The arrangements for managing medication were well managed by staff that supported those people who needed help to take their medicines safely.

Our observation of staff interacting with people gave a clear indication that they knew the most appropriate and best ways of communicating with people effectively and knew how best to support them. Staff were aware of people's individual choices and how to support those people who lacked capacity to make decisions for themselves.

Care plans were detailed and provided staff with clear advice on how best to support people to maintain their daily and night time routines, including how staff should respond to people's changing behaviours.

People were supported to maintain a suitable food and fluid intake. Staff supported people with their individual shopping requirements and helped them to maintain an appropriate healthy diet that was

flexible according to people's preferences and choices on a day-to-day basis.

People were supported to raise any concerns and complaints and we saw evidence of this. One complaint raised by a person had been supported to do so by the member of staff designated as their support worker. We saw full written details of the complaint made, the registered managers' timely initial response, and a timely response to the findings and outcome, all to the satisfaction of the complainant.

We found that the registered manager led by example, supporting staff when dealing with new, complex needs of people and providing opportunities for staff, people using the service and their families to participate in meetings to look for ways of further improving the service.

The management team carried out monthly checks and audits on how the service was being provided and if any areas of service provision could be further improved. The audit processes included, care delivery and support, maintenance of the environment and medicines management. Where any shortfalls had been identified, these had been quickly addressed with information included to detail any lessons learned. We saw evidence of the audits completed by the management team.

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.

Staff knew how to support and protect people from harm and had the knowledge and skills to keep people safe.

The recruitment of staff to work with vulnerable people was carried out safely to ensure only suitable people were employed.

Staff levels were appropriate to help maintain the safety of people using the service.

Is the service effective?

Good

The service was effective.

People were supported to be as independent as possible within their assessed and recognised capabilities.

Staff were supported with regular supervision and specialist training to provide them with the skills required to support people with complex needs.

Where people using the service required equipment to support their individual needs and lifestyles, this was provided.

Is the service caring?

Good

The service was caring.

People were supported by a team of staff that understood how to meet people's needs, ensuring that people's choices were respected and independence was encouraged whenever possible.

Care plans clearly detailed to staff how to provide support whilst maintaining people's right to dignity, choice, independence and privacy.

We saw that staff had developed appropriate relationships with people that enabled them to support people to engage with the

local community, further encouraging independence, choice and promoting equal opportunities.

Is the service responsive?

Good

The service was responsive.

People were supported by staff to participate in a range on both internal and external activities. This helped people from becoming socially isolated.

Care plans were developed to ensure people's complex needs could be met in the most appropriate way. Plans include supporting people's specific identified behaviours.

The service encouraged people to be open about the care they received and responded positively to complaints received.

Is the service well-led?

Good

The service was well-led.

The registered and deputy manager monitored the quality of the service being provided and encouraged participation of both staff and people living in the home to identify any improvements that could be made to further improve and maintain a safe and effective service and environment.

The management structure of the service provided clear leadership and staff felt confident in the support offered by both the registered and deputy manager.

Robust systems were in place to monitor the quality of the service being provided.

Lowry House

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 visit took place on 3 and 4 May 2017 and the first day was unannounced.

The inspection was carried out by one Adult Social Care Inspector.

Before the inspection took place we reviewed the information we held about the service. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

This was the first comprehensive inspection of the service since registering with the Care Quality Commission in November 2016.

During the inspection we spoke with seven staff including the registered manager, deputy manager and clinical services manager and one person who used the service.

We reviewed four people's care records, four staff personnel files including super vision records and records relating to the management of the service, including quality audit documentation. We looked at how medicines were managed and reviewed a number of medication records. We also looked all around the building to make sure it was clean, hygienic and a safe place for people to live.

Good

Is the service safe?

Our findings

One person who lived at the home told us they felt safe living there and that staff supported them well. Comments received included, "I do some things for myself and the staff support with things I need help with. It's a good and safe place to live. I like being able to close my own front door."

Staff spoken with and records seen confirmed that staff had received safeguarding vulnerable adults training. Procedures were in place to minimise the risk of abuse or unsafe care and staff we spoke with understood the types of abuse and examples of poor care that could place people using the service at risk. We saw that the service raised safeguarding alerts relating to incidents involving people who lived at the home, and where restraint had to be used to protect people from harm, and where staff had to intervene in a person's best interests. We discussed safeguarding alerts with the registered manager who provided a central log of concerns and safeguarding matters. From this we could see that each alert have been fully investigated and, where action was necessary, appropriate action had been taken. Each alert had an outcome recorded against it, including details of lessons learnt and how improvements could be made in certain circumstances. We were able to see that all the alerts listed had been notified to the Care Quality Commission (CQC).

People living at Cambian Lowry House had been involved in discussions about safeguarding and who they would go to if they were worried or concerned. We saw evidence in one of the activity rooms where people had drawn around their hand and identified on each finger the names of people who they could tell, for example, my brother, my mum and dad and my key worker [named]. This meant that people living at the home were being supported and encouraged to be proactive in safeguarding themselves.

Evidence was available to demonstrate that the manager reported matters to any external professionals that should be involved in reviewing the incident(s) and specialist support staff from the organisation, such as clinical leads or mental health specialist also provided support to evaluate and analyse incidents and look at preventative measures to minimise the risk of similar incidents recurring.

Prior to visiting the service the CQC had received two anonymous whistleblowing concerns. We discussed both concerns with the registered manager and clinical lead for the service, who is also the registered managers' line manager. We went through each part of both concerns in detail and found evidence to demonstrate that none of the allegations being made in the concerns could be substantiated.

Before any person came to live in Cambian Lowry House a full pre-admission assessment of the individuals needs would be carried out. This initial assessment would be completed by the organisations own assistant psychologist who would then feedback and discuss their findings from the assessment with the registered manager of the service. If, following the assessment, it was felt the service was an appropriate setting for the person to live and receive support; arrangements would then be made to begin a process for admission. This process would include staff being allocated to spend time with the prospective new service user in their existing environment, whilst at the same time developing a trusting relationship to aid the transitional period from one service/environment to Cambian Lowry House. The registered manager would also be

involved in this process and would visit the prospective service user.

From the initial assessment, both care plans and risk assessments were put in place. We found that all risk assessments were person specific and contained information to support the staff team for example, strategies to minimise the risk to other people using the service and staff when a person becomes both physically and verbally challenging. In one risk assessment relating to keeping the person safe, the assessment identified the signs and types of behaviour the person might display when becoming agitated. Details were very clear about how staff should interact and minimise the risk to all involved by using distraction techniques and other approved methods of control. All staff had completed Management of Actual and Potential Aggression (MAPA) training for which the registered manager was an 'advanced' trainer. This training was about people's potential behaviour change and providing an appropriate staff response, including decision making, physical intervention skills and post crisis support. All staff spoken with and training records seen confirmed this.

Each person living in the home had a personal evacuation plan (PEEP) in place for use in possible emergency situations. This information detailed the needs of each person and what level of assistance and equipment would be needed to help them exit the building in an emergency. The information was kept accessible to any emergency services that may require it in the event of such a situation arising. We were also provided with details of a business contingency plan that listed all possible contact information which could be needed in an emergency for example, gas and electric suppliers and all maintenance companies. The file also detailed that the provider had made an arrangement for temporary accommodation in four other Cambian services, plus details of local hotels. Transport details were also included.

Staff we spoke with knew how to report an incident especially those where verbal or physical aggression had been evident either from a person against staff or between people living in the home. Staff confirmed that the senior team responded quickly to reports of incidents and received support. Where lessons could be learnt from incidents, these were discussed at team meetings, training sessions or in individual supervision sessions. The manager confirmed that accidents and incidents were part of their monthly audit processes and details were sent to the head office of the organisation for monitoring and analysis.

We spoke with the manager about how staffing levels were planned for the service. It was explained that staffing levels were based on people's individual assessed needs and subject to agreement with the placing local authority prior to a person's admission into the home. They told us that staffing levels were flexible dependent on people's needs and if any individual activities or appointments were planned. For example, some people required the support of two members of staff to accompany them when leaving the home and this was planned for on the rota. Details on rotas indicated that staffing levels were flexible and that sufficient staff were employed to cover the rota on a day-to-day basis, also allowing cover for staffs annual leave and rest days. Staff we spoke with told us that staffing levels were always maintained at a sufficient level to support people safely and according to the person's assessed needs.

At the time of the inspection seven newly appointed staff were receiving induction training by a qualified trainer employed by the organisation. The manager also told us that an on-going recruitment drive was in place to recruit more staff to fill any vacancies that remained.

We spoke with three members of staff about how they were recruited to the service and they all confirmed that all required pre-employment checks were full completed before they were given a start date. We also looked at four personnel files to make sure staff had been safely recruited to work for the service. We saw that all relevant pre-employment checks had been carried out including a Disclosure and Barring Service (DBS) check. A DBS check reviews any information held about a person applying to work with vulnerable

people, including any previous convictions which could make them unsuitable for the post they have applied for.

There was good medicines management practice. All medicines were securely stored in a locked treatment room and only the senior member of the care team on duty had access to this room. Each person living in the home was registered with their own general practitioner in their local area and their medicines were delivered to the service on a monthly basis. We observed that people received their medicines as prescribed and at the right time. We saw the member of staff administering medicines check the persons individual medicine administration record (MAR) and the details on the medicine label to ensure they were administering the correct medicine(s) to the person. We found the medicines records had been accurately recorded and there were no gaps in signatures, with all medicines records only being signed after the medicine(s) had been administered.

One person who was being taken out in their car was at risk of having an epileptic seizure which in the event would require the administration of a certain prescribed medicine. We observed this medicine being signed out to the member of staff escorting the person and two signatures were obtained. The medicine was stored in a designated 'pouch' as an additional safety precaution. All staff had been trained in the administration of this medicine should they escort the person on an outing.

Some people living in the home were unable to verbally express if they required pain relief and details had been recorded on the front of their MAR under the heading, 'How will you know if I need this medication?' and details were listed of what staff should observe for that would indicate the person had pain. Staff received training in the safe handling and administration of medicines and had their competency assessed which meant that staff were sufficiently skilled to help people safely with their medicines.

People's cultural needs regarding medicine administration was also considered and for one person, staff had been provided with a coloured glass and spoon to use when preparing to administer specific medicines to this person.

The manager provided us with details of the arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as water temperatures (checks against Legionella) and fire alarm tests. Other maintenance and servicing checks were carried out by external contractors, for example, for fire safety equipment, gas appliances and electrical installations. Maintenance reports were available to demonstrate that equipment used in the home was regularly checked and serviced. Staff told us that the manager and senior staff conducted regular checks of the premises to make sure everywhere was clean and well maintained.

Good

Is the service effective?

Our findings

One person invited us to see their apartment and to talk with us about living at Cambian Lowry House. They told us they liked all the staff and that they thought the staff were "very good at their job." They also told us that they thought staff had the right skills to help the people living in the home. They said, "Sometimes [name] gets a bit aggressive with the staff and they have to help [name] calm down. All the staff know how to do this." Staff told us and records showed that they had received training that helped equip them with the knowledge and skills to manage behaviours that challenged and to use approved physical interventions effectively when necessary. We also saw evidence that the registered manager took appropriate disciplinary action with staff that had used any intervention incorrectly or inappropriately.
When any physical intervention had taken place, the registered or deputy manager would carry out a debriefing session with the staff to ensure the intervention used had been done so in a safe and effective manner.

We looked at how new staff were inducted to the service, training and supervision records and spoke with staff about the support they received to enable them to carry out their job roles effectively. Records showed that new staff attended a well-planned and thorough induction, including training in ways in which to meet the behaviour support needs of people who used the service. At the time of our inspection, seven new staff had started induction and were receiving the first day of training. Staff told us that induction to the service was detailed and comprehensive but was "very much worthwhile." As part of their induction, new staff spent an agreed amount of time shadowing experienced staff and being introduced to care planning and documentation that they would use in their support and care roles. One member of staff told us, "My induction was brilliant, I got lots of information over the first week, and did the mandatory training which included health and safety, first aid, safeguarding, food hygiene and MAPA (Management of Actual and Potential Aggression)." The staff we spoke said they felt the whole staff team had the right level of skills and knowledge to support people in the best way to meet their individual needs effectively.

Speaking with staff and records seen demonstrated that staff received regular supervision. Supervision focused on the needs of the people using the service and the personal development of the member of staff. One member of staff told us, "I get supervision with my line manager approximately every two months, but you get lots of informal supervision on a day to day basis. We've not had appraisals yet but the service hasn't been operating that long."

We looked at how the staff team communicated with people using the service. Due to the nature of their communication needs we saw each person was supported individually and various methods were used to ensure people's views were heard and understood. Staff had received training in the use of sign language (Makaton) and information was shared with people in pictorial format as well as written. Easy read documentation could also be provided. Details were available of a particular advocacy service that people could contact for support and one person using the service used an IPad to communicate with staff and others. Our observation of staff interacting with people gave a clear indication that they knew the most appropriate and best ways of communicating with people effectively.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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).

We checked whether the service was working within the principles of the MCA and whether appropriate and timely applications were being made to the authorising authority (Local Authority). We found a list of all DoLS authorisation requests on file and email evidence that the registered manager had chased up delays in some of the authorisations being approved by some local authorities. We, the Commission had been notified by the manager of the service of those DoLS applications that had been authorised.

There was evidence in one particular care file that demonstrated a best interest meeting had been held with relevant healthcare professionals, members of the management team and a family representative of the person using the service to discuss the potential use of a floor (Supine) hold during periods of crisis. We saw from records that staff had received training on the use of minimal restraint and individual care plans identified the levels of restraint that should be used for each person, for example, identification of the behaviour that can be displayed, signs that the person is becoming agitated and the appropriate de-escalation technique to be used. Training was nationally recognised, and in line with Department of Health guidance on the use of restraint.

Staff we spoke with told us that restraint would be the last option if de-escalation techniques had not worked in the persons best interests. If restraint was used, an incident form would be completed and an analysis of the incident would then take place, including reviewing care plans and associated risk assessments.

People using the service needed full support to buy their food and prepare meals. Each person was closely monitored to ensure they ate an appropriate diet and maintained their wellbeing. People's weights were regularly monitored and systems were in place to make sure people received varied meals and drinks at regular times. Each person had their own kitchen within the apartment they lived in from which staff supported them with their weekly shopping order and deciding what meal they wanted each day. We were invited to see one kitchen and saw that appropriate stocks of food were in place. To aid the person make a decision about what they wanted to eat, photographs of different meals and items of food were available to choose from. The person would then stick the photograph of the chosen meal(s) on the board and staff would then know what to assist the person to make or make for them. Where people had difficulty swallowing or had other medical issues relating to food or fluid intake, we saw that the Speech and Language Therapist (SALT) employed by the organisation had assessed the person and provided staff with best practice directions to support the person when assisting with meals and drinks.

We saw that people were supported to follow their religious and cultural beliefs regarding food and food preparation. Two people using the service were supported to follow a Halal diet and all food bought, stored and prepared was done in line with guidance provided by family members on behalf of the person using the service. All staff had been provided with support, training and information to ensure people's diversity; cultural and religious beliefs were upheld for the person and supported.

People's healthcare needs were supported and we saw that care plans identified guidance and interventions carried out by healthcare professionals both from the organisation (physiotherapist, psychologist, SALT) and from the community such as, optician and dentist. We saw that staff and family members supported people to attend hospital and other healthcare appointments. When someone is admitted into hospital for treatment, information is sent with them from Cambian Lowry House that clearly identifies the person's needs and how best for hospital staff to meet those needs. Staff from the service would also go to the hospital and provide care and support to the person.

We were taken on a tour of the premises and with the permission of the individual, were invited to see inside different apartments within the service. We found all areas to be clean, tidy and well maintained. The registered manager confirmed that a rolling programme of maintenance and decoration was in place. Bathing facilities were adapted and bespoke to meet the needs of the person and kitchen areas were planned with independence in mind. Risk assessments were in place where any person was involved in using any equipment and cleaning schedules were maintained to reduce any risk of cross infection developing.

Good

Is the service caring?

Our findings

One person told us, "The staff are really great, they look after all of us and some of us are really difficult" and "The night staff sit and talk with me until I'm ready to go to bed, they keep me company."

In our discussion with staff we found they knew people well, and could tell us about each person's likes, preferences and how they supported a person when their behaviour began to challenge. We also observed the interactions between staff and people who lived at the home. We saw staff respond to people in a caring, kind and compassionate manner and we saw people and staff enjoying a joke and laughing together, which created a warm and relaxed atmosphere.

We saw staff supporting and assisting people at their own pace, using gentle approaches to encourage people to maintain their independence. People were supported to go out into the local community, either being taken out in their own mobility vehicles or being supported to walk to the local shops not too far from the home. The meant the service promoted people's right to live as independently as possible whilst providing care and support that was person centred.

We looked at the information contained in peoples individual care plans to see how the service supported equality and diversity for the person. Care plans provided details about people's backgrounds, personal choices and their aspirations for the future. Discussion and consultations had been had with families who were able to provide supporting information about the person and how best to support and encourage the person to do as much as possible for themselves and maintain as much of their independence as possible.

The care plans we saw were individualised and written in a person centre way, using pictorial formats in parts to encourage participation of the person whose care plans they were. Care plans carefully detailed the support needs of the person, informing the staff team how to provide the care and support in a respectful and dignified manner. Our observation of staff demonstrated that they provided support to people with a caring, considerate and professional approach.

Within the Service User Welcome Pack given to people when moving into Cambian Lowry House were details of how to obtain the support of advocacy services. Advocates are people who are independent of the service and who can support people to make their views known. We were told that most people living in the home were supported by health care professionals and their families who were involved in making decisions where people needed support in this area.

Good

Is the service responsive?

Our findings

Most people that had been referred to Cambian Lowry House had been done so by various local authorities throughout the region. Some people having been on long stay secure hospital environments. During their first few weeks of living at the home, close monitoring of their health and clinical presentation was maintained to ensure they were settling in and their needs were being met.

Once a decision was made about moving into the home, people were supplied with a file (welcome pack) containing all the information about the service, for example, service user guide, things to do (activities and places to go in the local community), safeguarding and mental health act, including how to access and use advocacy services. All the information provided was in various formats including easy read language and pictorial format.

People had access to interpreters and staff had or were being trained in British Sign Language and Makaton. Staff also encouraged people to practice their religion and maintained any culturally specific dietary requirements. We saw evidence of this in the individual kitchens we saw.

Each person living in the home had a care plan that had been developed to guide staff on how to support the person throughout the day and night. Staff had received specific and approved training to support people with certain activities.

Care plans were detailed and provided staff with clear advice on how best to support people to maintain their daily and night time routines, including how staff should respond to people's changing behaviours. Staff we spoke with told us that care plans were detailed enough for them to provide person specific care, especially for those people with complex needs and that they regularly shared information with the senior staff as part of the review process. Maintaining contact with family members was an important part of people's daily lives and during our inspection we saw evidence of people being supported and escorted on a one to one basis to visit their relative.

We spoke with the registered manager and clinical services manager about reviews of care plans. They told us that any review would involve the person, their families and any external healthcare professionals as required. The provider also employed other specialist staff, such as a psychologist who could be involved in reviewing care plans and in providing advice, especially when reviewing people's behaviour support plans. Staff we spoke with told us that they could see that care plans were an essential part of sharing information about supporting and enabling people to lead their lives as independently as possible.

People were able to personalise their apartments and one person told us that they enjoyed being involved in planning things for their 'new home' and we saw that all furnishings were of high quality and each person had a lockable unit in their apartment to provide them with the facility to lock away their personal possessions. Where people had capacity, they had been offered a key to their apartment in order maintain their rights and privacy, however, the locks could be overridden by staff in an emergency situation.

People had a timetable of activities, including attending community resources, visiting relatives, using public transport, attending in-house activities and attending social events. People would complete activities alone or with staff support and assistance. Staff told us that some people required support to engage with some of the planned activities, but people were never forced to participate in an activity if they refused or showed signs of becoming agitated. People's participation in both internal and external activities helped to prevent them from becoming socially isolated.

One person we spoke with told us that if they had a complaint they would tell [manager named] or one of the staff [named]. We saw evidence of a complaint raised by one person who had been supported to do so by the member of staff designated as their support worker. We saw evidence to show that the complaint had been taken seriously by the registered manager and a letter of apology had been sent to the person, followed by a full investigation of the complaint which was followed by a letter informing the person of the outcome. The manager told us that complaints were used to identify lessons that could be learnt and was shared with the staff team.

Good

Is the service well-led?

Our findings

Cambian Lowry House was managed by a registered manager who had been in post since October 2016 and became registered with the Care Quality Commission in January 2017. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

One person who used the service told us, "The manager is great and so is the deputy manager. They come around and see us every day and make sure we are okay and happy. You can talk to them if you're worried about anything."

During the inspection we observed both the manager and deputy manager interacting well with people and from those interactions it was apparent both managers' knew the best way to communicate with the individual, having knowledge of people's particular behaviours and the best approaches to be taken when interacting with them.

Staff spoken with were very positive in their views about the overall management of the service and their comments included, "The management of the service is very good. Both the manager and deputy manager are very approachable and supportive", "The manager [name] is very good, he knows the business inside out, he leads on MAPA (Management of Actual and Potential Aggression) training and he is very knowledgeable with all behaviours and disabilities and how to meet people's needs" and "We have a very good manager whose is approachable and has an open door policy so we can speak with him or the deputy at any time, which is really good support."

The management team carried out monthly checks and audits on how the service was being provided and if any areas of service provision could be further improved. The audit processes included, care delivery and support, maintenance of the environment and medicines management. Where any shortfalls had been identified, these had been quickly addressed with information included to detail any lessons learned. We saw evidence of the audits completed by the management team.

The provider also had a Quality Surveillance Team (QST) who required all results from the monthly audits to be sent to them. These were then reviewed using a traffic light colour system to identify the level of compliance with the expected quality standards for the organisation. Any audit processes falling in the 'red' category were sent to the senior management board, including all policy reviews and checks. The QST also investigated any serious incidents, safeguarding matters and Care Quality Commission notifications. All reports had to be with the QST by the 5th of each month. We saw copies of the audits from January, February, March and April 2017 and each identified any actions that had been completed from the previous month.

Daily risk assessments were carried out for each person using the service with any incidents occurring being logged, investigated and actions taken to minimise the potential for the same incident to re-occur.

The provider used key performance indicators (KPI) to identify and gauge the overall performance of the team with the information then being analysed at service level to identify the potential development of any themes or trends.

People living at the home were invited to complete a pictorial survey requesting their views and opinions about the service they were receiving. Four people responded to this request and no significant issues were identified.

Staff we spoke with told us that they were given guidance, support and encouragement to further develop their skills and knowledge and to develop confidence when supporting people with complex needs. Further support was also provided through regular staff team meetings. Minutes were provided of meetings held in January and February 2017. Matters discussed included, health and safety, safeguarding, MAPA, medication, finance, staff management, handovers, reports and fire register. Other agenda items included forthcoming training for all staff, lessons learnt, themes and trends and suggestions for improvements within the service including action plans.

Providers of health and social care services are required to inform the Care Quality Commission (CQC) of significant incidents and events, for example, allegations of abuse. Both the registered and deputy manager had ensured that the CQC were informed of such matters in a timely manner.

Staff spoken with and information available demonstrated that good partnership working was taking place with other community and health care services. This involved external agencies that worked in collaboration with the staff team to ensure people using the service had their rights upheld to access and participate in appropriate employment projects, educational opportunities and community links.