Reach (Supported Living) Limited

Reach Supported Living Limited – Salisbury

Inspection report

The Portway Centre
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Salisbury
Wiltshire
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Tel: 01722432438

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Reach Supported Living Limited Salisbury is a supported and independent living service providing extra care and domiciliary support services to eight people with learning disabilities and (or) additional physical or behavioural difficulties. People have their own tenancies in three shared bungalows and are supported by staff, with 24 hour care.

This inspection took place on 11 October 2016. This was an announced inspection which meant the provider had prior knowledge that we would be visiting the service. This was because the location provides a supported living service to people in shared accommodation and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

At the time of our inspection a registered manager was in place at 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 persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager and the team manager were both available throughout the inspection.

Systems were in place to manage risk and protect people from abuse. Staff were aware of their responsibilities and knew what actions they needed to take to ensure people were protected.

We saw two examples of unsafe practice relating to medicine management concerning the recording of people's medicine and the storing of one person's medicine. We raised these with the registered manager and team manager who took immediate action to address these concerns. All other medicine practices were safely managed.

Staff were appropriately trained and skilled. They received a thorough induction when they started working for the service. They demonstrated a good understanding of their roles and responsibilities. Staff had completed training to ensure the care and support provided to people was safe and effective to meet their needs.

People received care and support from staff who had got to know them well and who encouraged their independence to be maintained. People told us they were happy with the care they received commenting "I like living here I'm happy" and "I know all the staff and I'm happy to talk to them".

Staff knew people's individual communication skills and abilities and had taken steps to ensure people could communicate in ways that were appropriate for them. Details of how to communicate with the person appropriately and actions to take were recorded and this was regularly reviewed and evaluated.

Care plans were personalised and detailed daily routines specific to each person. People's likes and dislikes were clearly recorded and captured events that were meaningful to people in the way they wanted staff to

support them. The service had spent time finding out about people's favourite music, activities and routines in order to provide person centred care that met their current and developing needs.

During our inspection we saw that notifiable incidents had not always been reported to the Care Quality Commission (CQC). The service had not reported two notifications of abuse or allegation of abuse. The registered manager told us "In addition to reporting incidents to the local authority and vulnerable Adults Team we will ensure that all notifications will be sent to CQC".

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Information relating to people's private finances had been kept in care plans which were accessible by all staff. This increased the potential for financial abuse to occur.

We saw two examples of unsafe practice relating to medicine management concerning the recording of people's medicine and the storing of one person's medicine.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom.

Is the service effective?

Good

The service was effective.

Staff received regular one to one meetings that enabled them to discuss any training needs or concerns they had. A plan was put in place if there were any actions to be addressed from these meetings.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

People's health care needs were assessed. Staff recognised when people's needs were changing and worked with other health and social care professionals to make changes to their care package.

Is the service caring?

Good

The service was caring.

People had been encouraged to make and be involved in decisions about their care.

Care was delivered in a way that took account of people's individual needs and in ways that maximised their independence.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and were aware of people's preferences, their likes and dislikes. Staff listened to people and acted upon their wishes.

Care records clearly identified how people wished their care and support to be given and were person centred in their approach.

Staff were proactive in supporting people to participate in the activities of their choosing.

Communication between staff was shared effectively ensuring that staff had an excellent understanding of people's needs and how to meet them.

Is the service well-led?

Good

The service was mostly well-led.

Notifiable incidents had not always been reported to the Care Quality Commission (CQC).

There were systems in place to monitor the quality of the service provided and to promote best practice.

There was a strong leadership team who promoted the values of the service, which were focused on providing individual, quality care.

Reach Supported Living Limited – Salisbury

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 11 October 2016. This was an announced inspection which meant the provider had prior notice that we would be visiting. This was because the location provides a supported living service to people in their own homes, and we wanted to make sure the provider would be available to support our inspection, or someone who could act on their behalf.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. An inspection of the office from which the service was run took place and visits were made to people living in three shared bungalows. Phone calls were also made to people's relatives to gain their feedback and health professionals were contacted. The service was previously inspected on 24 June 2014 and was found to be meeting all standards checked. The service has since moved location and the provider was part of a merger which sits under The Pobl Group. This inspection was the service's first rated inspection.

Before the inspection we checked the information we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with five people being supported by the service, three relatives, five staff members and one housing manager who had worked alongside the service. We also spoke with the registered manager and the team manager. We reviewed records relating to people's care and other records

relating to the management of the service. These included the care records for five people, five staff files and a selection of the provider's policies.

Requires Improvement

Is the service safe?

Our findings

At this inspection we saw that information relating to people's private finances had been kept in care plans which were accessible by all staff. We raised this with the team manager and the registered manager that this increased the potential for financial abuse to occur. The registered manager has informed us since our inspection that "All financial records will be maintained in a safe and secure cabinet in a financial file, only the people who need to will have access. The team manager completes regular financial checks to prevent any financial abuse. In addition the registered manager audits are in place to ensure these arrangements are robust and mitigate any financial abuse".

During our visit to one of the bungalows we observed a member of staff coming out of a person's bedroom wearing gloves. This staff member went into the staff office to retrieve an item and then returned to the person's bedroom to continue supporting with care. This practice did not follow safe infection control measures and increased the risk of potential harm. We raised this with the team manager and registered manager. The registered manager has since told us a staff meeting including refresher training is planned to cover the importance of measures to prevent cross contamination when completing personal care. Staff would also be offered further personal hygiene and infection control courses.

We saw one practice of poor record keeping relating to medicine management during our inspection. One person's medicine administration record (MAR) stated that the person was to have cream applied twice daily. We saw this had only been signed for once every other day and not as the MAR directed. The medicine was not prescribed for 'use when required' (PRN) so should have been given in line with the directions.

The team manager explained that a conversation had been held with the person's GP that this medicine was no longer required to be given every day and that the GP had agreed it could be given as the person required it. However this had not been updated on the person's MAR or documented that this conversation had taken place. We saw that a review of this medicine had taken place on 30 August 2016, but this stated to continue with the medicine and made no reference to reducing its application. The team manager said they had been trying to get the MAR updated and it may have been documented in the communication book but was not sure of the date this took place in order to check. After the inspection the registered manager told us "The team manager has already asked the doctor to update the administration of the meds to PRN, and Boots are to be instructed to reflect this on the MAR sheet. PRN guidelines for this medication are to be produced and staff made aware".

Medicine that needed to be kept in a fridge was stored in a locked container on the person's designated shelf of the fridge. We saw that for one person's medicine the container was not locked. This increased the risk for potential harm that this medicine could be accessed by other people living in the shared accommodation. We raised this with the team manager and the registered manager. The registered manager told us "All staff have been reminded that this medication should be locked immediately after use".

All other practices relating to medicines were managed safely. People had a medicine profile in place which

showed what medicine the person had been prescribed, if it was PRN, why it had been prescribed, the date it started and the date it should be completed by. The side effects for the different medicine's people were on were documented so if a person became unwell staff could check if this was a possible side effect of the medicine.

At the start of every new shift a medicine count was completed by staff as a safe practice. This was recorded on a daily sheet. Each person had a locked cabinet in their room where their medicine was kept. If the person needed assistance with managing their medicines staff would keep the key to this cabinet. Staff received annual competency assessments to ensure they administered medicines correctly. One staff member told us "We order medicines and Boots deliver. We record on the MAR's and in the diary if a person doesn't want to take their medicines and record this as a return. We have one hour in which to retry offering the medicines to the person. We phone the GP if it is something important they have not taken".

People we spoke with told us they felt safe and staff were always available to help them. Comments included "I feel nice and safe here" and "I am happy and feel safe". One relative told us "[X] is safe; there is always a carer there if she needs one. They are the same regular staff". Staff had all received safeguarding training, and were aware of their responsibilities in reporting concerns, and the concerns of those they supported. Staff told us "I understand safeguarding is to protect all individuals from anything untoward, I would report to the manager, or if about the manager I would go through safeguarding direct", "I would protect any vulnerable adult from abuse. I would report to a senior or manager and I would go higher if necessary and log everything" and "If there was an issue I would raise it with my line manager". The team manager commented "We do continual safety talks with people, it's on-going".

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. The team manager told us "We haven't ever stopped anyone taking risks, we advise people on things". We looked at the risk assessments in place for people and saw these clearly detailed why the risk assessment had been put it in place, the potential risks and what it meant to the person if they could not continue with the opportunity in question, such as 'Couldn't access my social activities'. The risk assessments were being regularly reviewed.

Each person had an emergency information sheet in place which recorded the person's immediate contacts, any medicines the person was on and allergies. Hospital passports had been created for each person to accompany them if they were rushed to hospital in place in an emergency. These passports detailed important things for other healthcare professionals to know about the person and what the person would like known about them. For example one hospital passport highlighted how the person needed their food cut up to prevent any risk of choking. Another person's passport contained information on how that person liked to communicate. This meant that people would be supported in appropriate ways if they required support away from their home.

For any incidents or accidents staff completed an incident report which went to the team manager for investigation. Once completed this would be sent to the company's health and safety team to be logged. The team manager told us "I would Investigate and speak to staff and the person concerned. If needed the person's risk assessment would be updated, or a referral to the GP for a review of medicines would be made". Any incidents were logged on each person's file.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. However the service had recently lost two members of staff and had been using agency to cover some shifts whilst they recruited new employees. The team manager told us "We have a mandate with one staff agency that we use, that they send people we have had before who know our people and their routines. We only use

agency alongside regular staff where there is more than one staff member needed in a bungalow, so there is always a core staff member present and they are not alone".

Staff we spoke with confirmed that staffing is not normally a concern and as only been a struggle more recently with two staff leaving. Comments included "We are struggling at the moment whilst recruiting, everything is always covered", "We have a supportive team, there is not usually agency, only when shortages happen" and "Staffing is good most of the time, it's rare that we need agency". One relative said "There are enough staff". Another relative commented "More agency staff are being used since the organisation merger three months ago; [X] responds better to long term staff and wouldn't be as happy if the higher amount of agency staff was to continue". The registered manager informed us "We are currently in the middle of a recruitment drive after the recent departure of two support workers. We are also reviewing the rates of pay for support staff in order to increase the recruitment take up".

We looked at the staffing rotas and saw they were colour co-ordinated to account for the three bungalows. We saw that shift times allowed for a half an hour overlap to ensure a handover could be completed between staff. The rota also showed what activities people had planned for that week so staff could be deployed effectively. The staff rota was on a two weekly cycle and relief staff had their rota up to December so they knew what shifts they were working. The team manager told us "Staff retention is really good; most have been with us for the three years".

The service followed safe recruitment practices. The registered manager explained how the provider's human resources department oversaw the recruitment process and confirmed with them when information was obtained. This included references and enhanced background checks for prospective staff. The registered manager sent us information relating to these staff checks after our inspection, so we could check the appropriate information had been obtained and people were suitable to work with vulnerable adults. The team manager told us "Our interview pack is consistent with our values, the values of choices, rights, person centred approach. We look for people who have basic skills such as cooking, the way they interact with people and if they have had several jobs in a short space of time. We have an excellent team".

Good

Is the service effective?

Our findings

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. The team manager told us "Care staff are matched with people, all people supporting in bungalow [X] have autism training to meet those people's needs, and all staff in bungalow [X] have to be epilepsy trained". The team manager further told us about the different relationships staff had with people commenting "Staff have individual relationships with people, for example one staff member is able to encourage one person with care when the person may not respond as well to another staff member". Staff we spoke with appeared knowledgeable when discussing people's needs and knew people well as individuals. During a team meeting we attended we saw staff raising any changes in people's behaviours that they had noticed recently.

New staff were supported to complete an induction programme before working on their own. They told us, "The induction went through certain files and risk assessments and what to do in the event of a fire. I shadowed and met people, and support the same people" and "Safeguarding was asked about in my interview, I shadowed and got to know people, I was introduced to everyone when I started". We saw that staff files recorded when new staff had completed their probation review and had their induction learning evidence signed off.

Staff told us they received regular training to give them the skills to meet people's needs. There was mandatory training of core skills for subjects such as manual handling and first aid and then specialised training available depending on the needs of people being supported. Staff comments included "We have lots of training, manual handling, safeguarding, medicines and more" and "We have regular training for medicines, we complete an in-house questionnaire, and are observed". We saw that the majority of staff had or were in the process of completing their diplomas in health and social care. This further qualification was also offered to the relief staff.

Training records were kept online and the system was colour coded to show when training had been completed or was due. The team manager explained that the training would not show up as completed until the training certificates had been received. The system would flag up any training that had expired and staff would not be allowed back on shift until this was completed. The team manager told us "Reach are excellent for training, they soon chase me if any training is out of date. We have a league table that comes out and we get named and shamed for being at the top for any outstanding support plans, one to one supervisions and training. It's a healthy competition to keep us on our toes which is good".

Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. A plan was put in place if there were any actions to be addressed from these meetings. These actions were then reviewed at the next one to one to check the progress that had been made. The team manager told us the senior leads in the house were able to observe staff members and report back any concerns. Staff commented "Supervisions are regular; they are good if you have concerns", "Supervisions are useful, we get feedback from them" and "They listen and understand your point of view".

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. We saw in people's care plans that where someone lacked the capacity to make a specific decision, mental capacity assessments were in place and best interest meetings had taken place first involving the person's family where appropriate.

For people that were unable to manage their financial affairs a Court of Protection appointee was in place or a relative with the appropriate legal authorisation. The Court of Protection staff came to the service annually to complete an audit of all the financial transactions the service had supported people with. A list had been sent by the Court of Protection to the banks confirming which members of staff were authorised to withdraw this person's money on their behalf. Staff had to take identification with them each time they withdrew money on the person's behalf. All transactions had been recorded on a financial sheet and clearly stated the reason for any withdrawal along with receipts that had been numbered.

Easy read information was in place to help people understand about this process and the support if they were unable to make decisions. One member of staff told us "Some people are not able to make decisions for their own health and safety. We have a care plan written up for this and other professionals are involved".

We saw one document dating back to 2014 for authorisation consent for assistance with medicines. We saw that this had been signed by a staff member and not a person with the legal authority to make that decision on behalf of the person. This was the only document in place like this; all other decisions had been appropriately consented to. The registered manager took action immediately and informed us that "The team manager is to work with the care manager to ensure that there is an appropriate authorisation in place and that this is reflected within the care plan".

Staff supported people who could become anxious and exhibit behaviours which may challenge others. We saw that the provider had a physical intervention policy in place which stated that 'Physical interventions should only be used after all other methods such as distraction and diversion have been exhausted. Physical interventions should only be used alongside a working policy, positive support plan and risk assessment'. We saw risk assessments and behaviour plans were in place which provided detailed guidance to staff on what the behaviours of concern might be, what a person's triggers may be and strategies to manage these such as 'Staff to be consistent in approach and remind person of personal space' and 'Allow some time for [X] to get to know new staff and feel confident with them'.

We saw a bespoke restrictive practice was being used during care support. A health nurse had provided training for staff in how to do this correctly. This practice had been agreed after a best interests meeting had taken place in which a core team of health and social care professionals, the person's family and staff had attended. This practice was clearly detailed in the person's care plan and a recording sheet was in place to document the use of this. This was being regularly reviewed and staff we spoke to were able to describe the correct methods they employed in these situations which corresponded with the person's care plan. One member of staff told us they felt confident in supporting people commenting "We have had behaviour training, I feel confident in these situations. We go through the support plans".

People's dietary needs and preferences were documented in their care plans and most people were supported by staff to prepare their meals. Menu plans that people had chosen for that week were displayed and one person told us they were having their favourite meal for dinner and this corresponded with what was recorded on the menu. One person told us "I cook, I like making pasta best". Staff comments included "People normally eat together but they don't eat the same things, they choose what they want", "One person makes their own sandwiches, other people are supported to prepare the food with staff, we try and retain or improve the skills they have got" and "One person has their fluids monitored. One person will make

drinks and assist preparing food but is unable to understand if the oven is hot or cold". One relative commented how pleased they were that their loved one was being encouraged with healthy foods and had noticed the difference in their appearance.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People all had health action plan containing information in pictorial versions also which described the support they needed to stay healthy. Relatives we spoke with felt the needs of their family members were well met by the service commenting "She is well looked after", "[X] sees the GP, staff accompany her if she needs to discuss anything with the doctor, they help her understand what the doctor is saying" and "The GP is very good and responsive, they have regular three monthly review meetings with the GP and his team to discuss [X] needs".

We saw that one person was recorded as being very anxious in medical settings and would refuse to discuss anything with medical professionals. The service had worked closely with one private hospital to support the person and as a result the hospital had a non-uniform on the day the person attended in order to help relax them. The team manager reported this had been a success.

Wiltshire Council had responsibility over the maintenance of the building, and all maintenance concerns were reported directly. The team manager told us "They have been prompt in addressing things". A housing manager who had previous dealings with the service told us "Information in relation to repairs is passed to us promptly and staff on site have facilitated access when required". We saw that people's bedrooms had been decorated in the style of their choosing and the communal areas also displayed artefacts from the people that lived there. One relative told us "It is a lovely place and has a garden with garden furniture so [X] can sit out when it's a nice day".

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. People told us they were happy with the care they received commenting "I like living here I'm happy", "Staff will help me wash my hair before bed, I like to do it then" and "I know all the staff and I'm happy to talk to them". We saw that people felt comfortable in approaching the staff and enjoyed chatting and sharing a laugh with them. One relative said "There are three good regular carers in the bungalow, who are easy to talk to and very welcoming. [X] is very happy there".

We saw that each bungalow had a noticeboard up in the entrance which displayed the time of day and photos of staff to show which staff member was on duty when. The team manager told us "Previously the people we support lived in a residential home, and they have been so empowered by living in the bungalows".

We saw one undignified episode of care in which a staff member shouted out to other staff about the personal care needs of one person instead of alerting them in a more discrete manner. We raised this with the registered manager and team manager. The registered manager told us "The team manager is arranging a staff meeting/training session to discuss the importance of dignity and respect when undertaking personal care. We have sent guidance to all staff to remind them that dignity should be maintained at all times.

All other staff interactions we observed demonstrated respect towards people. One person told us "Carers knock on the door before they come in". A staff member told us "We ensure people are covered during personal care and ensure that they are happy with what we are doing". We heard staff asking people's permission before removing documents from their bedrooms and where people were sat in the lounge staff would ask first before entering their bedrooms. The team manager told us "When staff are in people's homes they ask them if it's ok to use the microwave or the cooker first, people here are so empowered".

Staff told us that people were encouraged to be as independent as possible. Two people we spoke with told us they had jobs and one person had recently been assisted to purchase their own car so they could be supported to go out when they chose. Staff told us "We encourage people to do things for themselves" and "We give people choices of what they want to do". One relative said "[X] does a bit of cooking which is supervised, and does little things around the bungalow and tidies her room". The team manager commented "People are happy, they have a fulfilled life, they have choices, they are so different from five years ago".

People and their relatives were given support when making decisions about their preferences for end of life care. We saw people had 'When I die' care plans in place which recorded people's wishes and preferences for their care at this stage of their lives. The service had spent time ascertaining people's views on these important decisions so care could continue to be tailored to the individual.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. We saw that people had their life story in place which gave a history for staff of what each person had achieved and experienced to present day. Examples were given in care plans of what made a person's 'Best weekend' so staff could understand what people enjoyed. People's care plans were very visual and contained many pictures of the person doing the things they liked and showing the experiences they had enjoyed.

People's likes and dislikes were clearly recorded and captured events that were meaningful to people in the way they wanted staff to support them. For example we saw on one person's care plan it stated under 'Things I don't like; going from light to dark'. The care plan further recorded that if the person did not want to do something or showed signs of becoming anxious staff were to guide away from this situation. Another person's care plan recorded that liked 'Having regular staff that are familiar with my ways' and did not like 'A change of staff at short notice'. The service had spent time finding out about people's favourite music, activities and routines in order to provide person centred care that met their current and developing needs.

People were supported to plan for their future and share their dreams and goals of things they wanted to achieve. We saw that actions had been put in place around each person's goals and who would help support the person in reaching these. A cultural spiritual and identity care plan was in place recording what events people liked to celebrate and if they held any religious beliefs so staff could be respectful in supporting the person to maintain these. We saw a 'Guide to working' was in place for each person which detailed how staff should work with the person. This had a photo of the person and detailed what that person needed support with and how they liked to be supported.

Staff knew people's individual communication skills and abilities and had taken steps to ensure people could communicate in ways that were appropriate for them. People had communication care plans in place which stated if the person had any impairment that impacted on their ability to communicate. Details of how to communicate with the person appropriately and actions to take were recorded and this was regularly reviewed and evaluated. For example staff told us one person had their own vocabulary of using different names for things and staff had learnt this in order to converse easily with the person. We looked in the person's care plan and saw all the words the person used and their meaning had been recorded as a reference for staff.

The team manager told us about one person who found it hard to make decisions commenting "I remind staff not to speak for [X] but to give her time as she will get her words out". We saw that the service had worked closely with a behaviour therapist and put measures in place to help this person such as 'Talking Mats' (Talking Mats is a communication framework that enables people who have difficulty communicating to express their views). Staff we spoke with were aware of how to take time and listen when this person communicated with them. During the team meeting we observed staff discussing a 'forward planning board' which was a system that had been put in place to help a person understand what events were coming up in the week. Staff told the team manager they had reviewed this but the person did not want to use this

method any more. The team manager told staff "That is fine, it's her choice, we can remove this", demonstrating the service were proactive in evaluating and finding ways to enable people to effectively communicate.

People's needs were reviewed regularly and as required Where necessary health and social care professionals had been involved and relatives also had the opportunity to be part of reviewing their loved one's care needs. One relative told us "Staff let [X] know she has care plan meeting, and she lets us know as [X] wants me to attend. We are both involved with her plan". We saw that any changes or updates to a person's care came into the office and the paperwork was immediately amended and sent back out to the bungalows so staff had the up to date information available to inform them of people's needs.

The team manager told us "We have person centred reviews for everyone". We looked at previous reviews that had taken place and saw these were very detailed, recording who the person had chosen to invite and where the person wanted the meeting to take place. Throughout the review pictures had been included to represent the person doing the things they enjoyed and wanted to keep doing and things that were important to them. We saw one person had stated in their review they would like the bungalow patio extended and a new table and chairs purchased. We saw that the service had helped the person action this and it was now in place. Another person's review had included information on the person's preferred meals and drinks and stated the person "Only likes onions if they are finely chopped".

Communication between staff was shared effectively ensuring that staff had an excellent understanding of people's needs and how to meet them. There was a half an hour overlap between shifts to allow staff time for a thorough handover. The team manager told us this had been reduced and trialled at 15 minutes instead but it was reported by staff not to be long enough, and was extended back to half an hour. At every shift the staff member finishing their shift would not leave until the new staff member had completed a medicine count and financial check as a level of precaution and to reduce potential errors.

Handover sheets were in place for staff and we saw these contained checklists to be completed on each shift which included reading people's communication diary, checking fridge temperatures and ensuring communal areas were clean. Each person had their own communication diary in place for staff to pass information over and these were kept securely in the staff office.

We saw that staff had been given information on the protocols of communication with families and other professionals. This detailed what was appropriate information for staff to be able to discuss and share about the people they supported. This guidance was in place to ensure staff did not pass on private information about a person to someone who did not have the right to know these personal details.

People were able to choose what activities they took part in and suggest other activities they would like to complete. Each person had a weekly plan in place of activities they had chosen to do and staff would support people by arranging these for them or accompanying them on these activities. People had a range of social events they participated in which reflected their interests and hobbies. Staff had good knowledge of people's preferred activities commenting, "One person has a personal trainer, and goes to a music club and day centre", "[X] likes to goes shopping every day, there is a park and ride right outside the bungalow", "One person is going to a concert at the weekend" , "[X] likes cake making, flower arranging, gardening, going to see shows and often writes to the Queen and gets replies" and "[X] has access to a mobility car which can take two other people and a driver, so they all go on days out to the seaside, air displays and shopping".

During our inspection visits to the bungalows we saw that people were engaged in activities of their own

choosing. A couple of people were out and about in the local town, one person was doing arts and crafts in their bedroom, and another person was watching their favourite television series. One person told us "I didn't want to go out today, I'm going out tomorrow". One relative commented "[X] is much more independent living in this bungalow than if she was at home, as I wouldn't have had the confidence to let her do so much on her own".

We saw a supported holiday policy in place and staff told us people were assisted to go on holidays of their choosing. We spoke with one person who proudly showed us lots of pictures from their recent holiday abroad commenting "It was the trip of a lifetime". One staff member showed us leaflets of all different events and activities people could choose from commenting "We have leaflets of different places so people have this visual side to help them choose the activities they want to do". Other staff commented "If people want to do anything we help arrange it, they are asked every morning what they want to do", "Everyone does different activities" and "If people wanted to do a group trip they could but it's not their choice, they have coffee together but prefer to do their own things".

Relatives were encouraged to be involved in their loved one's care and were able to visit people without any restrictions. Relative's comments included "They will ring me if she is unwell" and "I live nearby, so visit every day to keep them on their toes. Not much is communicated to me because there is no need, as I am kept informed when I visit every day".

The service had good links with the local community. Staff were proactive and made sure that people were able to maintain relationships that matter to them. Two people went to work during the week and one person walked to the nearby bus stop and caught the bus to travel to their job. The team manager told us "People are very popular in the community; they know a lot of people". The three bungalows people lived in were all in the same street and people would pop over to one another's bungalow for a cup of tea or shared activity. The team manager said that the bungalows would take it turn to host Christmas lunch and would join together to celebrate this festive period. The provider was in the process of arranging to have internet access put into the bungalows so people could have online facilities in their home, as one person had raised this as something they would like to have access to.

The service had not received any complaints but people we spoke with were confident if they did raise a concern it would be investigated and responded to in good time. One staff member told us "If I received a complaint from someone, I would alert the manager and write it in the communication diary". People had access to an easy read complaints process which gave them information on how to raise concerns, should they need to.

Good

Is the service well-led?

Our findings

During our inspection we saw that notifiable incidents had not always been reported to the Care Quality Commission (CQC). A notifiable incident for example is if a person had died or had an accident, and this information is used to monitor the service and ensure they responded appropriately to keep people safe. The service had not reported two notifications of abuse or allegation of abuse. We raised this with the registered manager and team manager and spoke about what must be notified to CQC and were informed this would be addressed going forward.. There had been some confusion over who had responsibility to notify these events to CQC. We saw that the service had informed the local authority of these events, worked closely with other health professionals and had supported people appropriately. The registered manager told us "In addition to reporting incidents to the local authority and vulnerable Adults Team we will ensure that all notifications will be sent to CQC".

The registered manager had only been in post for six months at the time of our inspection and was registered manager and regional manager for four of the provider's locations including Reach Supported Living Limited Salisbury. At each of these locations a team manager was in place who was responsible for overseeing the day to day running of the service. The registered manager was present at the office on the second day of our inspection. The team manager visited the bungalows daily and knew people well, speaking easily about people's needs, daily activities and preferences.

Staff told us they felt supported by the management team commenting "I feel supported, I can raise any issue, we have a good manager", "I have met the registered manager, she came and said hello. The team manager is really good, if staff have any issues they support us, and are easy to chat too" and "The registered manager is so new at the moment, she's taken an interest and popped in to see us all". One relative told us "The service is better than satisfactory. I can speak to the team manager if there is a problem".

Staff meetings were held at the office monthly and we attended one during the second day of our inspection. A nominated staff member attends the meeting from each bungalow and reports on events from that bungalow. The meeting was interactive and staff were given a lot of talking time to raise any issues. We saw the managers and staff worked together to discuss and develop ideas to meet people's needs.

Staff had access to information necessary to fulfil their roles. The provider policies and procedures were available in each bungalow. We saw in the staff offices at each bungalow information relating to safeguarding, the complaints process and medicine guidance was all clearly displayed.

The service had a positive culture that was person-centred, open, inclusive and empowering. It had a well-developed understanding of equality, diversity and human rights and put these into practice. We reviewed the provider's statement of purpose which stated the purpose was 'To support individuals to live life to the full' and promote principles of independence, choice, dignity, respect and community living. Staff were aware of these values commenting "We are told about these and they are available for us to read" and "The values of the service have been discussed with us".

People were empowered to contribute to improve the service. Regular house forums were held in the bungalows to check if people were happy living together and comfortable with the staff that supported them and if they had anything to raise. We reviewed minutes from some of the previous meetings and saw that where people had raised suggestions for improvement these had been actioned. One person being supported by the service was involved in interviewing potential new employees and sat on the panel alongside the team manager.

The provider had employed an engagement officer who was responsible for looking at ways to involve people in the service and ensure that people's views were represented. The team manager told us "Reach are very supportive, there is an engagement officer to support people who has asked if there was anything people wanted to do that they couldn't access". People and their relatives were sent an annual survey by the company to feedback their views on the support and care received. Any compliments the service received were shared with staff and then sent to the quality assurance team at head office to be logged. The team manager told staff during the team meeting that they are going to start keeping a log of these compliments at the office also, so these can be available for staff and people to view.

During our inspection we asked the team manager about The Duty of Candour (The Duty of Candour is a legal duty to be open and honest with people who use their service when something goes wrong with their care). The team manager was unaware of this term or the regulation that had come into force in April 2015. The principles of this regulation were being met by the service already; however the term was not familiar to the manager or staff. During the staff meeting the team manager was honest with staff explaining it had been an unfamiliar term to his knowledge previously. The registered manager explained to staff about The Duty of Candour and how it ensured that complaints were dealt with appropriately. This was included in the meeting minutes which were then circulated to all staff. The registered manager has since informed us that "We are updating our complaints policy to incorporate The Duty of Candour and will also circulate a briefing note to all staff in the organisation".

Quality assurance systems were in place to monitor the quality of service being delivered. All financial transactions were audited by the team manager weekly and receipts were checked for any items that the individual would not normally purchase to ensure nothing untoward was happening. Medicine audits were completed and medicine administration records and the daily reports of medicine counts were checked for errors or gaps. The service had not had a medicine error for two years. The registered manager completed regular audits of the service and across the three bungalows. We saw this had been done recently in September 2016. Areas looked at included best interests decisions, safeguarding, risk assessments and speaking with people being supported by the service. No concerns were noted from this last audit but if required an action plan would be put in place for the team manager to address these areas.

The management structure had good levels of support within their roles. The team manager told us "The registered manager is there as much as I need; she comes to all the staff meetings which are monthly. She doesn't micro manage. The registered manager has come in and been brilliant, if I need her she responds quickly. I have administration support here at the office and it is brilliant, I couldn't do without it".

The registered manager told us she had been well supported during her induction into the role commenting "Communication from senior managers is good, I have been well supported". Managers were able to attend regular training and participated in manager meetings to share information and knowledge with their peers. The team manager told us "This is the best service I have worked in".