Complete Care & Enablement Services Ltd

Complete Care and Enablement Services

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 inspected Complete Care and Enablement Services on 11 and 12 April 2016. The service is also known as CareTech by some of the people who use the service and their relatives. As this was a supported living and domiciliary care agency service, we contacted the service manager (in the registered manager's absence) one working day before the inspection. This was so that they could let the people who lived there know we were coming. At the last inspection in October 2013 we found the service met all the regulations we looked at.

At the time of our inspection, the service was supporting 14 people in five 'supported living' properties. Supported living describes the arrangement whereby people are supported to live independently with their own tenancies.

The properties were located in Tameside and Trafford and the service was in the process of setting up three new properties to support a further seven people in their own tenancies. In addition to supported living, the service also provided domiciliary care for five people in their own homes.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service told us they felt safe and the relatives we spoke with also agreed people were safe. Support workers could explain the various forms of abuse people might be vulnerable to and said they would report any concerns appropriately.

Staff rotas were based upon the number of hours of support people had been assessed as needing. People, their relatives and support workers told us they thought there were enough staff to meet people's needs.

We saw that facilities and equipment in the properties we visited had been checked and were safe. Comprehensive risk assessments were in place and people were supported with positive risk-taking.

People's medicines were managed, administered and documented correctly by support workers and we saw that people received their medicines in a person-centred way.

We saw that people's flats and shared communal areas were clean and tidy. People told us they were supported by staff to do their own cleaning tasks.

Support workers understood how the Mental Health Act (1983) and Mental Capacity Act (2005) affected the people they supported. The registered manager was working with the relevant local authorities to ensure that any deprivation of people's liberties was done so lawfully.

Support workers received the training and support they needed to care for the people safely and effectively. The service had implemented the Care Certificate, an induction programme for support workers new to care.

People who needed assistance to shop for and cook food were supported to do so by staff. Staff encouraged the people to eat healthy foods but respected people's meal choices.

We saw that the people were supported by staff to maintain their holistic health by visiting healthcare professionals such as their GPs, dentists and opticians.

It was clear that staff knew people well as individuals and we saw people and staff interacting in a warm and friendly way.

Support workers could give examples of how they promoted people's independence and respected their privacy and dignity. People told us that staff supported them with domestic tasks, such as cleaning, shopping and cooking.

We saw that people's support plans were person-centred and based upon their likes, dislikes and preferences. Care files contained information about how people liked to be supported in all aspects of their care and we saw that support plans were reviewed regularly.

People told us and daily records showed that people were supported by staff according to their support plans.

People told us that they had enough to do. They said they were supported by staff to engage in a range of activities and their relatives confirmed this.

There was an effective system in place for the audit and monitoring of safety and quality at the service.

People, their relatives and healthcare professionals involved with people using the service received an annual survey to feedback about the service. Support staff were asked for their ideas to improve the service in staff meetings and their supervision sessions.

The staff understood the vision and values of the service and we saw that it underpinned the support they gave to the people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People using the service told us that they felt safe. Staff could describe how to protect vulnerable adults and said they would report any concerns.

People's support had been thoroughly risk assessed and control measures were in place to mitigate any risks identified. People were supported to take risks when the benefits were deemed to outweigh them.

Medicines were managed and documented safely and were administered to people in a person-centred way.

Is the service effective?

Good

The service was effective.

The service was compliant with the Mental Health Act (1983) and the Mental Capacity Act (2005) and staff knowledge of the legislation was good.

Records showed and staff told us they were trained and supported appropriately to care for the people using the service.

People were encouraged by staff to make healthy meal choices, although support workers respected people's right to eat the foods that they liked.

Is the service caring?

Good

The service was caring.

People and their relatives said that the support workers were caring. We saw staff interacting with people in a kind and friendly way.

Support workers respected people's privacy and dignity. People told us that they were supported by staff to be independent.

People were involved in designing their support plans and had

access to advocacy services if they needed them.

Is the service responsive?

Good

The service was responsive.

People's support plans were comprehensive. A process was in place to support people making the transition from hospital to supported living.

People who were supported by staff to do activities told us that they had enough to do and their relatives agreed.

No formal complaints had been made to the service and we saw that the registered manager had managed minor issues and feedback appropriately.

Is the service well-led?

Good

The service was well-led.

The system of audit and monitoring in place was comprehensive.

People, their relatives, staff and other healthcare professionals had opportunities to feedback on the service. The people had their own forum they had called 'Happy Days.'

There service had an open culture. Staff could describe how the service's vision and values underpinned the support they provided.

Complete Care and Enablement Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 April 2016. The inspection team consisted of one adult social care inspector. We telephoned the service manager (in the absence of the registered manager) a working day before the inspection. This was so that there would be someone at the office on the first day of the inspection and to arrange visits for us to meet the people using the service.

Prior to the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service. This involved contacting the local authority safeguarding team, clinical commissioning group and Healthwatch Trafford. They had no information of concern to share with us. After the inspection we also contacted five healthcare professionals directly involved with the people using the service; those that responded gave very positive feedback.

During our inspection we spoke with four people using the service, the registered manager, the service manager and five support workers. After the inspection, we spoke with two people who used the domiciliary care service and four people's relatives by telephone.

We visited two of the properties to meet people using the service. One was a shared house and the other a building containing individual self-contained flats. We also spoke with people, their relatives and healthcare professionals involved with the service.

As part of the inspection we reviewed four people's care files at the main office and four where people were supported, three staff personnel records, various policies and procedures, staff training records, four people's medicines administration records, audit and monitoring records and other documents relating to the management of the service.

Good

Is the service safe?

Our findings

All of the people we spoke with said they felt safe being supported by the service. One person told us, "The staff make me feel safe", a second person said, "They remind me to keep myself safe", and a third commented, "I feel safe in [the registered manager's] hands in particular." We asked relatives if they thought the people using the service were safe and they all said yes. One relative said, "There's always someone there when [name] needs them."

The support workers we spoke with could explain what the different forms of abuse were and how the people they supported might be vulnerable. They told us they would report any concerns they had to their team leader or to the service manager or registered manager. We saw that staff had received training on safeguarding and there was a safeguarding policy in place which was available to the staff at each service location. This meant that staff understood how to safeguard the people they supported and knew how to report any concerns they had.

We looked at how new staff had been recruited to make sure that only staff suitable to work in the caring profession had been employed. When we checked the recruitment records of three support workers we saw that each had a Disclosure and Barring Service (DBS) check; the DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. Personnel files contained copies of photographic ID and an application form. The service had created an additional form which specifically asked prospective employees to explain how they had been occupied since the age of 16, including any gaps in employment. Each file also contained at least two written references obtained before the staff member started work. The registered manager explained that people who used the service were involved in interviewing prospective staff; she said that this often helped the people develop therapeutic relationships with new staff quicker than if they had not been involved in the process. This meant that the recruitment process used was robust and people using the service were involved in recruiting new support workers.

Each person supported by the service had different needs which meant they required varying levels of care and support. Some people received minimal support with daily tasks whereas others needed two-to-one support from staff to maintain their tenancy safely. The amount and type of support people needed was based upon detailed assessments made by the organisations funding them in conjunction with the service provider. We saw that the service used the hours of support each person needed as the basis for staff rotas; this made sure there were enough support staff available to meet each person's needs.

We asked the people if they thought there were enough staff to support them and they said there were. The support staff we spoke with also thought there were enough staff to meet people's needs, as did people's relatives. The registered manager explained that the service had grown significantly in the last year and in that time 34 new members of staff had been employed. She said that this had meant they had not needed to use agency staff for over six months. A healthcare professional involved with people using the service told us, "I have observed the staff turnover to be low, with low reliance on agency staff." There was also an on-call system in place so that support workers could get advice and support from a manager 24 hours a day.

Feedback from the people, their relatives and the staff at the service showed that there were sufficient staff employed to meet people's needs safely.

As part of the inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw that medicines were stored and administered safely. Medication administration records or MARs were up to date with no gaps in recording. People had detailed assessments of the support they required with their medicines, which included their capacity to understand what medicines they needed and how they should be taken. Based upon this assessment, some people managed their own medicines, some did this with support and others had their medicines managed for them by the service. Medicine risk assessments and care plans were in place, along with information on what each medicine was and its potential side effects. There were also medicine protocols for 'as required' medicines. 'As required' medicines are those administered when a person feels like they feel they need them, rather than on a regular basis.

Records showed that the support staff who administered medicines had received appropriate training, which involved observations of their competency by the registered manager. We observed a support worker preparing medicines for a person they supported. The support worker wore gloves to remove tablets from a dosette and to pour out liquid medicines. They also updated stock lists for each medicine so that an accurate count was maintained. We saw that the support worker did not sign the person's medicine administration record until after they had taken their medicines; they commented, "I've got to make sure [name] takes them before I sign the MAR." This meant that people were receiving their medicines safely and in a person-centred way.

Each person using the service had a Personal Emergency Evacuation Plan or PEEP in their care file; this explained how they should be supported to leave the building in the event of an emergency. The service had a business continuity plan for emergency situations and we heard how it had been put in action a few weeks before our inspection when a flood had occurred at one property. The people using the service had been moved to a local hotel as a result and the registered manager said she was impressed with how well the staff and people had coped with the upheaval. She also told us that one positive outcome of the incident was that a person they had assessed as not able to go on holiday due to the negative impact the change in environment might have had done so well during the episode that the service now felt confident to arrange a short break for the person in 2016, should they wish it.

We looked at the records for gas and electrical safety and for fire equipment checks. In some properties the landlord had taken responsibility for gas and fire equipment checks and in others, the service did this. Each property had a team leader which managed the required checks on behalf of the service and made sure everything was up to date. We looked at the records in the two properties we visited and found that all the necessary inspections and checks had been done which meant that the facilities and equipment used were safe.

People's care files contained risk assessments for various aspects of the care and support they received, including using the kitchen, smoking cigarettes, personal care, self-neglect and exploitation by others. Risk assessments differed according to people's needs and behaviours and included risk control measures when risks were identified. One person was being supported to regain their independence and we saw that this involved an increasingly hands-off approach by staff when out in the community. Risk assessments and care plans detailed how staff had begun to observe the person from a distance rather than accompany them directly in order for the person to feel more independent whilst still being safe. The person told us, "They took a step back so I can't see them. It's independence. It doesn't feel like they're there 24/7 (all the time)." This meant that the service identified and managed risks appropriately and supported people to take

positive risks when the benefits were assessed to outweigh them.

We found that the two properties we visited as part of the inspection were clean and tidy and also smelled fresh. People we spoke with told us that staff supported them to clean their flats or shared accommodation and in one property we saw staff rotas for cleaning the communal areas. One person said, "They help me tidy my flat", and a second person said, "I do the cleaning and the staff do it with me." One support worker explained that as most of the people in that particular property had come from a hospital environment where some had lived for many years, they were not used to cooking and cleaning for themselves. The support worker said, "I prompt them (the people) with tasks, like washing the pots or cleaning the kitchen. Every morning I ask [name] to clean their kitchen with me." People assisted with personal care told us that support workers wore personal protective equipment (PPE) such as gloves and aprons for this. One person said, "Staff wear gloves and aprons with personal care. They're brilliant with infection control."

Good

Is the service effective?

Our findings

We asked people who used the service if they felt in control of their lives and were supported to make their own decisions. They told us that they were. One person said, "I decide what I want to do", a second person told us, "They helped me gain confidence over taking control of my care", and a third person said, "I decide, but with help." Relatives agreed that staff supported people to be as independent as they could be and to make their own decisions.

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 make 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 community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DiDS). In supported living, the care provider must request that the local authority applies to the Court of Protection for DiDS authorisation if they think the person's liberty must be deprived to keep them safe.

Some of the people using the service were restricted by provisions under the Mental Health Act 1983 (amended in 2007) (MHA) and had Community Treatment Orders (CTO) in place. CTOs enable people to live under supervision in the community; they usually contain conditions which must be met otherwise the person could be recalled back to hospital.

The care files we saw made reference to people's capacity to make decisions and what support they may need to make them. Support workers we spoke with described how they obtained consent from people prior to assisting them with personal care or activities. They understood the process of best interest decision-making when people lacked the capacity to make certain decisions. The support plans of people with CTOs contained information relating to their recall conditions, for example compliance with medicines, so that staff would know to inform managers when certain things happened. The staff we spoke with knew which people had CTOs in place and what their conditions for recall to hospital were. This meant that the service was complying with both the MCA and MHA and staff knew how to support people to make decisions.

We asked the registered manager if any of the people using the service were subject to a DiDS authorisation. She informed us that the relevant local authorities were in the process of applying for them through the Court of Protection. The service's part in this process had been to provide information for each person in the form of risk assessments, support plans and a contingency plan for each person should they need extra support to manage their mental health needs. The registered manager's knowledge and understanding of the process was excellent.

Support staff were trained to restrain people whose behaviour could challenge others physically. We read the care file of one person and saw that there was a detailed risk assessment and support plan in place which described the person's behaviours at baseline, as they escalated, when they went into crisis and then into recovery. This is known as the assault cycle. Alongside this, there was an outline of measures for staff to use during each phase of escalation, for example distraction techniques, and a plan which detailed when 'as required' medicines were needed and which restraint holds should be used to keep the person safe. We could see from records when and why the person had been restrained by staff and what other measures had been taken, for example, when 'as required' medicines had been given. Regular progress meetings were held between the various healthcare professionals working with the person and the service. One purpose of these meetings was to evaluate whether the use of restraint by staff had been an appropriate response to their behaviour. The registered manager told us that feedback from these meetings to date had supported staff's use of restraint and found it to be a proportionate response to the person's behaviours. This meant that support workers who were trained to use restraint did so only when it was required. The service also kept records of when restraint was used so that external healthcare professionals could have oversight of its use.

We asked the people using the service and their relatives if they thought the people were well trained and they said that they did. One person told us, "I think they (the staff) are excellently well trained", and a second person said, "Yeah, they know what they're doing."

The support workers we spoke with said that they had received a comprehensive programme of training, which included mandatory units such as fire safety, safeguarding and medicines administration, as well as more specialised courses on acquired brain injury, self-harm and personality disorders. The service also worked in partnership with a mental health network for people whose symptoms include voice hearing and provided specialist training for their staff to support such people.

The service used an electronic learning system which kept track of which courses support workers had completed and which were still outstanding. The service manager said they checked this system weekly and sent out reminders to the staff who had not completed the training courses they were allocated. The service paid the support workers for the training they did; the service manager said they felt it provided staff with an additional incentive to keep up to date. Records we saw showed that support workers had received the training they needed to support the people safely and effectively.

We saw that the Care Certificate had been implemented for both employees joining the service who were new to adult social care and those who had experience working within the sector. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. We asked support workers who had joined the service in the last year if they had completed the Care Certificate; they said that they were working their way through it and two showed us detailed booklets compiled by the provider in which they had recorded their progress.

Support workers told us that they received regular supervision with the service manager and one support worker who had been at the service for almost a year told us that their annual appraisal was due. We looked at supervision documents for three members of support staff and confirmed this was the case. Staff we spoke with said that they felt supported by the registered manager and service manager and we saw that four support workers had been promoted to team leader within the service. This meant that staff got the training and support they needed to do their jobs effectively and progress in their careers.

The people using the supported living service were assisted by staff to shop for and prepare their food if they

needed to be. Support workers helped people to make shopping lists and either shop daily for food items or do a weekly shop, depending on people's preferences. One person told us, "They (the staff) help me cook food." In one of the properties we visited, the meals people ate were documented by the staff supporting them. We saw that some people ate mainly processed foods and did not eat fruit or vegetables so we asked the staff if they encouraged the people to make healthier choices. Two support workers agreed that some people preferred convenience foods, but gave us examples of how they suggested healthier foods. Both support workers concluded that when people had capacity to make their own decisions, they could eat what they liked. One support worker said, "We try as much as we can to encourage a healthy diet, but [name] likes what [they] like", and the other support worker told us, "When we do the weekly shopping we make suggestions, but they're adults and it's up to them." This meant that people were supported to shop for and prepare the foods that they liked and staff respected the wishes of people to make unwise choices in line with the MCA.

People told us that they saw other healthcare professionals when they needed to and their relatives agreed. One person said, "I tell staff when my appointments are and they put them in the diary and remind me." We saw from care records that the people who used the service had seen a range of healthcare professionals, including GPs, dentists, members of their learning disabilities or mental health teams and opticians. They also attended hospital outpatients' appointments. Visits were recorded in a specific section of each person's care file and upcoming appointments were noted in the shared diary kept in the office. On the second day of our inspection one person was accompanied by staff to see their GP and came back with a new medicine. We observed as the details of the appointment were handed over by the support worker to their team leader and the new medicine was booked in. Staff we spoke with knew the healthcare professionals involved in each person's care. This meant that the service supported people to maintain their holistic health.

Good

Is the service caring?

Our findings

We asked people and their relatives if they thought that the support workers were caring and they told us that they were. One person said, "They respect me", a relative told us, "They're very caring. I'm quite satisfied with the care [name] gets there", and a second relative commented, "I think they're caring and [name] always speaks highly of them."

We saw support workers respecting people's privacy by knocking on doors before entering their private space. People and their relatives told us that staff always did this. One person said, "They knock on my door", and a second person said, "I get my own privacy and freedom." The people we met looked well cared for; they were dressed in clean clothes and their hair was tidy. It showed that the support workers promoted people's dignity by supporting them to take care of their personal appearance.

We wanted to know how people's independence was promoted, so we asked the people and the support staff. One person said, "They're helping me get back to doing things", and a second person told us, "They allow me to think about what my care should be and to be more independent." All of the support staff we spoke with described how they gave people choices, for example, what to eat or what activities to take part in. One support worker told us, "I ask people to help me with whatever I'm doing", and another said, "I'll say to people 'if you do this, I'll do that'". A third support worker described how they had taught a person to make sandwiches using a hand-on-hand approach, where they had guided the person's hands during the task to show them what to do. Relatives we spoke with also felt that the service supported the people to be more independent. One relative said, "They help [name] to help [themselves]." This showed us that people using the service were supported to increase their independence by support staff.

We observed support workers interacting with people using the service. The language they used was warm and friendly and we heard staff laughing and joking with the people who reciprocated. The support workers we spoke with described the people they supported in positive terms, and knew about people's personal histories, their preferences, likes and dislikes. We saw that respectful language was also used in daily records, even when people may have had a bad day or had displayed behaviours that might challenge others.

Managers and support workers had all completed 'The Dignity Challenge' and signed up as Dignity Champions. The Dignity Challenge describes values and actions services which respect people's dignity should adhere to. Dignity Champions make a commitment to try and ensure the service they provide is compassionate and person centred. This meant the service actively sought to promote people's dignity.

We asked the people if they were involved in planning their own care and support and they told us that they were. All of the people we spoke with had seen their care plans, said they were reviewed regularly with them and felt they could change them if they wanted to. One person described how their support plans had been altered to fit around their work and social life; "They're very flexible", this person said of the service. We saw in one person's care file how after an initial assessment, the registered manager had emailed a person their support plans for them to either approve or amend. The person had emailed back some suggestions and

the registered manager had thanked them, writing, "It's a working document so we can add lots more details." We saw that most people had signed their care plans and where people had chosen not to, this had been noted by staff. This meant that people were involved in planning their support and felt able to change their plans if they wanted to.

In people's flats and the room's they had in the shared house, we saw photographs, people's own furniture and personal belongings, which meant that people were encouraged to personalise their accommodation. We saw that the rooms used for offices by staff were separate from people's flats or communal areas and were kept locked. This meant that people's confidential information was stored securely.

At the time of our inspection, all of the people using the service either had family members who could advocate for them or had court appointed advocates already in place; their arrangements were detailed on an advocacy support plan in individual's care files. The service had an advocacy policy and support workers said they would inform the service manager or registered manager if they felt a person needed an advocate to help make a decision or resolve a problem. We heard from staff that one person using the service would request an advocate directly when they felt they needed it. The registered manager had contact details for a local advocacy service and said she would refer people to it if they needed such support. This meant the service understood the importance of ensuring people's rights were protected.

Good

Is the service responsive?

Our findings

We looked at the care files of people who used the service, four at the main office and four at the properties where people were supported. Each file contained a contents page and had a consistent layout which made them easy to navigate. There was also a service guide in 'easy read' format which each person had signed to say they had either read, or had the contents explained to them by a member of staff. 'Easy read' is a written format designed to present information to people in a format that is easier to understand; sentences are usually short and text is accompanied by pictures. The service guide explained to people what they could expect from the service, the role of support workers and had information on keeping safe and reporting any safeguarding concerns.

We found people's care files were comprehensive. They contained people's life histories, detailed assessments of need, lists of people's likes and dislikes and a one-page profile that listed the good things about the person, what was most important to them and the best way to work with them. Each person had a comprehensive set of support plans. These included aspects such as mental health and/or learning disabilities, the activities of daily living, communication, leisure activities and relationships. Plans detailed the support people needed from staff, their own responsibilities and the goal or outcome the person wanted to achieve. We saw that each person had an aspirations and change support plan, which included short term and long term goals, such as holidays, jobs or increased independence.

Care files contained hospital support plans to go with a person should they go be admitted to hospital. There was also information on how to discuss health issues with the person, how they responded to pain and details of how a person may react if placed in certain situations. Each person also had a detailed financial support plan, which included a capacity assessment and best interest decision (if needed) and a personal budget plan. Personal budgets had been negotiated with the people who had capacity to do so and individuals had signed plans to say they agreed.

People's support plans were evaluated by staff in the daily records they kept for each person. We read three people's daily records for the two weeks prior to our inspection. We saw that the detail these contained depended on the level of support the person needed. For example, one person supported on a one-to-one or two-to-one basis had very detailed daily records which documented all the aspects of care and support they had received. This level of detail was required for the regular progress meetings the service had with the person's external healthcare professionals. Daily records for people supported on a less intensive basis were shorter but we saw that they did evidence that people were being supported according to their support plans. This meant that people were receiving the support that was documented in their support plans. One healthcare professional involved with the people using the service said of it, "They've created something bespoke and person-centred."

A proportion of the people supported by the service had come from hospital facilities for people with learning disabilities and/or mental health issues where they had lived for many years. Such environments are very structured; many people are often supported together and cared for as patients, so moving people from this type of environment to supported living represents a huge change for them and can present many

challenges.

We asked the registered manager how the service managed people's transition from a hospital setting to supported living. She explained that people undergo a comprehensive transition process, which involved support workers from the service going to the person's prior location to get to know them and to shadow staff. This then progressed to the support workers taking the person out. Towards the end of the transition, the person was supported by staff to visit their proposed tenancy, and then stay overnight a few times with a view to move permanently. The registered manager said that this process could take up to six months. One healthcare professional we spoke with said, "They have a really prolonged transition at a cost to themselves. It makes a difference when people move in and there's already a relationship in place." We saw the care files of people still in hospital who were in the process of moving to the new properties being set up by the service. The files contained detailed assessments and information about each of the people who were preparing to transition across. Support workers we spoke with said that they liked being involved in this aspect of the service and were glad they had the opportunity to go out to meet prospective new service users before they moved in. Another healthcare professional told us that the service was 'proactive' in terms of progressing people's discharge from hospital, but willing to work over a short or long period, depending on the advice of the healthcare professionals involved with the person, or the wishes of the person themselves.

We heard how the transition process had gone wrong for one person. The registered manager, service manager and support workers described how distressed they had been when the placement had broken down and the person had been recalled to hospital. However, the service had worked hard with the person's team of healthcare professionals to learn where mistakes had been made and modified the person's flat and support plans so that they could return safely. This had included a lead healthcare professional involved with the person chairing a support worker team meeting, so they could analyse events together and plan to move the person back in. This had happened several weeks later and at the time of the inspection, the person was doing well. As a result of their work with this person, the service was nominated as the provider's team of the year and won the regional team of the year award for 2015.

One healthcare professional we spoke with told us, "Not everything goes right all the time, but they're reflective and make changes. They don't give up on people", and a second said, "I find that all CareTech staff have a similar style of working; very much a 'can do' attitude, which runs through the company. The staff work with other professionals very effectively at resolving difficulties." This meant that the service understood that moving from hospital to supported living could be challenging for people and had created an extended transition process to better manage it. The service also worked as a team to learn from mistakes to meet people's needs more effectively.

Some people received support to take part in activities, so we asked people if they felt they had enough to do. One person said, "They take me out places", and a second person told us, "They take me to Tesco's and to football matches. Whatever I want to do, the staff are there for me." We noted that in the care files of two people supported to live in their own flats, leisure support plans referred people's activity plans, but we could not find them. We raised this with a staff member at the property. They explained that as the property had not been open long, the people were still adjusting to the supported living environment and that whilst they were supported to take part in activities, creating a structured plan was a goal but not appropriate at that time. Another support worker said, "Some people have resisted activity plans as they don't want to be stuck to them." Daily records showed that these people were supported to take part in activities. In another property run by the service, one person did have an activity plan which they drew up themselves weekly with the support of staff.

The activities people told us they did with staff included local walks, trips to sporting events, the cinema and meals out. Some people had been supported to attend courses, to volunteer and to work. One person told us, "They support me with what I want to do, not what they want to do." Relatives told us they thought that the people had enough to do. Two relatives commented that if their family members did not take part in activities, it was because they chose not to and not because the staff did not provide opportunities. One relative said, "They try and get [name] to go out and do an activity planner." Support workers described how they encouraged people to take part in activities and to try new things. One told us, "I take ideas to people. We get to know them and find out what they like." We also saw that it was possible for people to 'bank' their support hours to use for events or holidays. By speaking to people, their relatives and to support workers and by making our own observations, we saw that people were provided with sufficient opportunities to engage in activities.

We saw that the 'easy read' complaints policy was included in each person's service guide; it was discussed with them when they started with the service. None of the people or relatives we spoke with had made a formal complaint about the service in the last year. One person told us how they had complained verbally to the service manager about an issue that had been bothering them; they said that the service manager had resolved it quickly and to their satisfaction. A second person said, "I've never made a complaint. I have a very open relationship with everyone at CareTech." One relative told us, "I've never needed to make a complaint", and a second said, "I've not made a complaint but I'd be happy to approach them if I did. They're very friendly."

Records showed there had been no formal complaints made since the start of 2015 but we saw that some feedback and issues had been raised by people and their relatives informally to the registered manager. Records we saw showed that the registered manager had investigated and responded to the issues raised appropriately. This meant that the registered manager was responsive to complaints and feedback.

Good

Is the service well-led?

Our findings

We asked the people and their relatives if they thought the service was well managed. All of the people we spoke with told us they thought it was. One person said, "It's incredibly well managed. If we could clone the management team then everywhere would be as good", and a relative told us, "I'm absolutely satisfied with them. I think it's great." One healthcare professional involved with people using the service said, "CareTech are the highest standard of provider, effective at working with our most complex service users, and are a pleasure to work with. I cannot speak highly enough of the organisation, the staff and management", and a second said, "It's been a real breath of fresh air to work with people with the same passion I have", and added, "It's their flexibility and passion for the people."

Support workers felt that there was a happy atmosphere at the service and an open and supportive culture. One support worker said, "We have a really good team atmosphere. Everyone is happy and we know the service users really well", a second support worker told us, "Staff have all got a good rapport with the people. Everyone gets on really well", and a third support worker commented, "It's quite relaxed. It's a happy place."

There was a comprehensive system of quality monitoring in place whereby the service was regularly audited for safety and quality by the registered manager, service manager and team leaders. A new in-depth audit tool had been introduced three weeks prior to our inspection; it involved looking in detail at one person's care file (including their medicines administration records), two staff personnel files and surveying both people and staff. People were asked if they knew how to complain, if they needed advocacy services and whether they thought staff were caring. Staff were asked about their knowledge of the service's vision and values, how accidents and incidents were reported and medicines management.

The service manager said that the new audit tool was quite time consuming, but they and the registered manager were committed to auditing all of the people's care files within the next two months and would then repeat the process every three to six months after that. Prior to the new system, people's care files and support plans had been reviewed and updated by support workers in team meetings and various aspects of each property had been audited by the team leaders. This included an audit of finances, medicines and staff availability. The registered manager reported on a wide range of aspects to senior management within the service on a monthly basis and attended a meeting with her peers. At this meeting any serious incidents were discussed and analysed for trends and training uptake by staff was evaluated. The registered manager said that the discussion of people's support plans at staff meetings and the weekly team leader reports would continue and the in-depth sampling audit would be in addition to this.

At provider level, there was a quality team and a compliance and regulation team who advised the registered manager on best practice, legislation and regulatory issues. The compliance and regulation team also completed an annual inspection designed to mirror that of the Care Quality Commission's. This meant the registered manager was supported by the provider to audit and improve the service.

We looked at the records for incidents and accidents that had occurred at the service to see if they had been

documented and monitored correctly. We saw that various incidents had occurred; most had involved one person and related to episodes of behaviours that had challenged others. We saw that these incidents were documented in detail and were discussed at regular meetings with the team of healthcare professionals involved in the person's care. In addition to this method of scrutiny, the service uploaded incidents to an electronic portal whereby an external service monitored documentation and identified any trends. These were then notified to the registered manager. Incidents or accidents which qualified as notifiable to the Care Quality Commission or CQC (for example, serious injuries, deaths or police call-outs) were also discussed in the monthly senior management meeting attended by the registered manager. We compared the incidents and accidents recorded at the service with the notifications received at CQC from the registered manager and found that she had made the correct notifications to us.

Records we saw showed that the level of audit and monitoring employed by the service to ensure safety and quality was appropriate.

People, their relatives, support staff and other healthcare professionals involved with the people had opportunities to feedback about their experience of the service. The registered manager told us that people, relatives and healthcare professionals were sent annual surveys by the service and their responses were collated into a report. The relatives we spoke with all said that they had received a survey. We read the report generated from the most recent survey undertaken at the end of 2016. Quotes from people using the service were all very positive, for example, "Staff support me really well and encourage me to access the community on a regular basis", and, "It's nice the staff are nice. It's homely. I'm happy."

The service had recently started a forum for people using the service in Trafford and Tameside whereby they would meet regularly in local venues. Prior to this, the people had travelled to meet with people supported by the same provider in North Wales, but it was decided this meant it was not easy for everyone to attend. The local forum had held two meetings so far in 2016; at the first meeting they had decided on a name for the group ('Happy Days') and had discussed ideas for activities and trips. We saw that on the back of these meetings, staff had obtained free tickets for some of the people to attend a match at a local football ground, which everyone had enjoyed.

Support workers told us that managers regularly asked them for feedback and ideas about how to improve the service, either in staff meetings or their supervision sessions. One support worker said, "They're always asking for ideas to make the service better", and a second told us, "In staff meetings we discuss ideas on how to do things differently and encourage people's independence." This meant that people, their relatives and staff were given opportunities to feedback on the quality of the service.

We asked the registered manager how she communicated the vision and values of the service to the support workers so that it would underpin the support they provided to the people. She told us that the vision and values of the service were discussed at team meetings, in staff supervisions and we saw that staff knowledge of them was now checked as part of the new audit methodology. We asked the registered manager what she thought the service was trying to achieve; she said, "To provide a really high quality service where people feel empowered. So that people have lives that aren't restricted." We also asked the support workers what the aim of the service was. One support worker said, "To enable and support people to gain further independence and to adapt people to an independent life. To reintroduce people back into the community as much as we can." All of the other support workers asked the same question mentioned promoting independence and providing a person-centred approach. This showed us that the staff understood the vision and values of the service; records and feedback demonstrated that this underpinned the support they provided.

The service as a whole and individual support workers and managers had signed up to the Social Care Commitment. This is a set of seven 'I will' statements that address the minimum standards required when working in care, such as promoting people's dignity, work co-operatively and maintaining confidentiality. This demonstrated the service's commitment to improving quality and raising standards.

The service worked in partnership with other organisations. The registered manager had recently volunteered to chair a local Skills for Care registered managers' forum which focused upon peer-led service improvement. The service also contributed to the local provider forums and invited staff from other services to attend training they had organised, for example, the staff of a day centre that people using the service also used. The service worked alongside various volunteer bodies to provide opportunities for the people using the service and people and staff had recently collected over 1000 Easter eggs for children using four local charities. This showed us the service worked hard to develop a community presence.