Leeds and York Partnership NHS Foundation Trust

St Mary's Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 11, 12, 13 and 14 July 2016. This was an announced inspection as it was part of the inspection of Leeds and York Partnership NHS Foundation Trust. We last inspected the supported living service in September 2014 and the service was rated overall good. However, during the inspection in 2014 we found a breach of the Health and Social Care Act 2008 because the provider had failed to ensure safeguarding concerns were reported through the correct channels. At this inspection, we found the provider is still not ensuring the system in place guarantees all safeguarding incidences are recorded in the correct way.

The service is registered to provide personal care to people living in their own homes. At the time of our visit the service provided personal care to 89 people with learning disabilities and/or autistic spectrum disorder across the city of Leeds.

The current registered manager was in the process of de-registering from that role as they no longer had day to day responsibility for the service. An operations manager was in post and told us they had started to apply to become the new 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.

Systems in place for the management of medicines were not robust enough which meant people were at risk of not receiving their medicines correctly.

There were not robust systems in place to monitor and improve the quality of the service provided. Data collated was not always analysed which meant improvements that could be made may have been missed. Not all safeguarding information was reported correctly.

The service did not use a staffing tool or risk assessment to evidence staffing levels had been reviewed based on people's needs and that levels in place were safe. We saw that people were well cared for but that staffing levels may impact on people's access to activities and the community.

Assessments were undertaken to identify people's care and support needs. Care records reviewed contained information about the person's likes, dislikes and personal choices. People and their families were involved in the assessment and review of care and support plans.

There were risk assessments in place for people who used the service. Risk assessments covered areas such as mobility, travelling independently and finances. This meant that staff had the written guidance they needed to help people to remain safe. Recognised tools for areas such as nutrition and pressure care were not used to help staff understand how to monitor and when to refer to professionals.

The registered manager and staff we spoke with had an understanding of the principles and responsibilities in accordance with the Mental Capacity Act (MCA) 2005. We saw examples of the process being followed but this needed to be implemented fully for decisions.

There were systems and processes in place to protect people from the risk of harm. Staff were aware of the different types of abuse and what would constitute poor practice.
Staff told us that their house manager was supportive. Most staff had received regular and recent supervision and an annual appraisal. The policy for this area was undergoing review to improve the support staff would receive. The new approach was awaiting approval at the time of this visit.

Not all staff training was up to date. Staff told us they had received training which had provided them with the knowledge and skills to provide care and support. The operations manager told us outstanding training will be completed by the end of 2016.

Recruitment and selection procedures were in place and we saw that appropriate checks had been mostly undertaken before staff began work. However some gaps in staff member's employment history had not been investigated or recorded.

People and family members told us that staff treated people with dignity and respect. Staff were attentive, showed compassion, were patient and gave encouragement to people.

People were provided with their choice of food and drinks which helped to ensure that their nutritional needs were met.

Staff at the service worked with other healthcare professionals to support the people. Staff worked and communicated with social workers, occupational therapists, hospital staff as part of the assessment and ongoing reviews.

The registered provider had a system in place for responding to people's concerns and complaints. People told us they knew how to complain and felt confident that staff would respond and take action to support them.

Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found during this inspection. You can see what action we told the provider to take at the end of this report.

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.

Systems in place for the management and administration of medicines were not robust, which meant people were at risk of not receiving their medicines appropriately.

Care and support plans contained risk assessments for areas such as mobility and travelling independently, but recognised tools for areas such as nutrition and pressure care were not used when needed.

Staffing levels were not risk assessed and a tool was not used to ensure they were safe. Safe recruitment procedures were in place but on some occasions gaps in employment had not been investigated and recorded.

Is the service effective?

Requires Improvement

The service was not always effective

All staff had received regular supervision and most had received an annual appraisal. Not all training was up to date. The provider had an action plan to be up to date by the end of 2016.

The staff had an understanding of the Mental Capacity Act 2005 and had received training. Good examples of recording Mental Capacity Act and best interest was seen but this needed to be completed for each person in the service.

People were supported to maintain good health and had access to healthcare professionals and services. Staff encouraged and supported people to have meals of their choice.

Is the service caring?

Good

This service was caring.

People told us that they were well cared for. People were treated in a kind and compassionate way.

People were treated with respect and their independence,

privacy and dignity were promoted. People were included in making decisions about their care.

The staff were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People told us they had access to a wide range of activities and opportunities to develop their skills. Staff did not always record activities to enable them to evidence the positive outcome for people.

People's care and support plans were person centred. The use of person centred review tools was not implemented in all services.

People we spoke with were aware of how to make a complaint or raise a concern.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance system in place was not robust enough to ensure quality and safety.

Staff were supported by the operations manager and their house manager. Staff felt able to have open and transparent discussions with them through one-to-one meetings and staff meetings.

The service had an open, inclusive and positive culture. People and staff were involved in developing the service and had opportunities to provide feedback.

St Mary's Hospital

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected this service on 11, 12, 13 and 14 July 2016. This was an announced inspection as it was part of the inspection of Leeds and York Partnership NHS Foundation Trust.

The inspection team consisted of two adult social care inspectors and two experts by experience who had experience of a family member using a similar service or using a service themselves. A specialist advisor in nursing for people with a learning disability also supported this inspection.

Before the inspection we reviewed all the information provided by the service and data we had received via statutory notifications since the last inspection. We contacted the local authority for feedback on the service. They did not report any concerns. We also received feedback on the service from three visiting professionals.

At the time of our inspection visit there were 89 people who used the service.

During the inspection we spoke with 23 people who used the service and six of their family members / representatives. We spoke with some people in their own home and others in a group at the provider's office during a meeting arranged by the operations manager. We spoke with family members over the telephone.

We also spoke with the operations manager, four house managers and 26 staff. We did this during our visits to people's homes, the provider's office and during a meeting arranged by the operations manager.

We looked at nine people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the service and a variety of policies and procedures developed and implemented by the registered provider.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place to manage people's medicines. Most people required full support from staff to ensure medicines were correctly ordered, received, stored, administered and disposed of. The providers policy dated April 2016 stated 'The standard of record keeping should ensure the records are properly completed, legible and current, providing a complete audit trail of medication'. We saw stock of medicines received was not always recorded and balances of stock were not always kept. We saw there were gaps on the medication administration record (MAR) where we could not tell if medicine had been administered to a person. The house managers we spoke with told us the gaps had not been investigated by the provider.

We saw on one occasion the stock of 'as and when required' medicine had been dispensed by the pharmacy in 2012 via a monitored dose system. There was no expiry date recorded, meaning staff would not know when the medicine should no longer be used. The house manager we spoke with told us dates of expiry were not known for this medicine.

Where people were prescribed 'as and when required' medicine there was not always a corresponding protocol to tell staff under what circumstances they should administer the medicine. On one occasion we saw a person had two protocols for the same medicine that gave different advice.

Where people were prescribed topical creams and lotions the service did not have administration charts which contained safe administration guidance for staff. The operations manager and house managers we spoke with told us they would implement topical medicine administration records (TMAR's).

We visited people in their own home and saw the storage of medicines in people's own homes was secure, but we saw on one occasion medicines were stored near to the house hob and cooker which meant the medicine was exposed to very high temperatures, which could alter the medicines effectiveness when taken. The provider in this instance was responsible for managing medicines for people because they were unable due to their learning disability. The staff members moved the medicines immediately when we highlighted this.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The administration of the medicine and the balance remaining was checked by two staff.

Staff told us they received frequent training in medicines management and were observed each year for their competence. We saw a workbook staff completed each year to demonstrate their knowledge in medicines management which included observations of practice. However we could not determine if all staff had completed this as there was no system in place to record if staff were up to date. The operations manager told us they did not know the number of staff members currently up to date or not with medication competency.

The provider did not have a system in place to audit medicines and therefore was not aware of all of the issues we found with medicines management during our inspection. The operations manager told us this was something they would look to introduce in the future.

As part of the inspection process we spoke with people who used the service who needed help from staff to administer their medicines. People did not report any problems and advised staff were reliable. One person said "Staff do my medications and they are good at it."

We concluded there was a risk of people not receiving their medicines as prescribed, and this was a breach of Regulation 12 (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about their understanding of protecting people who used the service. Staff were aware of the different types of abuse and what to do if they witnessed any poor practice. The operations manager and house managers we spoke with were aware of local safeguarding protocols. Staff told us they had received training in respect of abuse and safeguarding of vulnerable adults. They told us the training had provided them with the information they needed to understand the safeguarding processes which were relevant to them. Records confirmed 87% of staff had up to date safeguarding training.

People who used the service and the relatives we spoke with during the inspection were aware of who to speak with should they need to raise a concern. They told us they felt safe and trusted the staff who helped to provide them with the care and support they needed. One person told us "I feel safe." A family member said "I feel my relative is safe, and they are happy. I don't worry. I know they are well cared for."

We found the service had safeguarding and whistle blowing policies and procedures in place. These outlined to staff what action they needed to take if they suspected a person was at risk of abuse from anyone. Staff confirmed they understood the policies in place.

We saw records to confirm the operations manager had notified the local authority of safeguarding incidents. The operations manager had taken immediate action when incidents occurred in order to protect people and minimise the risk of further incidents. However we found records of incidents held locally had not always been communicated to the NHS reporting system as they should have been. Since the inspection a more robust system has been implemented to ensure this does not happen in the future.

There were risk assessments in place for people who used the service. For each area of need a person had a care and support plan, and there was a corresponding risk assessment for each need. Staff were skilled in understanding when to refer to a dietician or to district nurses for advice and support. However, we found recognised tools to assess risk in areas such as nutrition where for example a malnutrition universal screening tool (MUST) were not used where people needed them.

We saw good examples of how risk had been assessed to support people to be more independent. For example a person was supported to develop their skills and confidence enabled them to spend time in their home alone for periods of time and people travelled independently on public transport. Staff told us they were keen to promote independence through positive risk taking. A person supported told us this approach meant they could use the bath independently because staff put plans in place to make it safe.

The house managers had mapped all the known hazards in each service such as moving and handling, lone working and fire. There were systems in place to mitigate these risks and the house manager's work together to improve where they highlight issues. For example, they recognised the system in place for fire was not

consistent and each service had differing documents and advice from experts such as fire officers. They worked with the provider's fire specialist to ensure fire systems in place were fit for purpose and effective. This included updating the personal emergency evacuation plans for each person supported. This project was still ongoing at the time of our visit.

Each house manager ensured incidents and accidents were recorded and communicated to the provider's risk management team.

Each of the services had differing staffing levels to ensure people's needs were met. We saw in some cases people who were more able and independent had a higher staffing ratio to those people with complex physical and communication needs, which required more physical support. We spoke with house managers and the operations manager and they told us there was no dependency tool used to determine the levels of staff on shift for people. There was also no risk assessment to evidence the levels of staff on shift were safe. This meant people were at risk of not having enough staff to meet their needs.

For example we saw in some services two staff were on shift to support four people with complex needs. Those two staff would be required at times to support one person with personal care, meaning no staff could be with the other three people monitoring their wellbeing. Staff were able to describe to us how they ensured on these occasions people were safe and how the amount of time was kept to a minimum. However the staff and house manager told us no-one had ever been harmed in these periods of time. But they did feel only basic tasks such as personal care could be completed and no-one could be supported with activities or access the community, so people were restricted at times.

One house manager told us "The staffing levels were set a long time ago and some people no longer go to day services and this impacts on outings." We discussed this with the operations manager and they told us they would look to find a system to review staffing in each service to ensure the levels of staff was safe and met people's needs. We saw in the providers quality report 15/16 that they are working with Leeds university to develop a bespoke tool to assess staffing requirements.

Visiting professionals and families told us they noticed the consistency in the staff teams and how this meant people received support from staff who had better relationships and understanding of their needs.

During the inspection we looked at the records of eight newly recruited staff to check the recruitment procedure was effective and safe. Evidence was available to confirm appropriate Disclosure and Barring Service checks (DBS) had been carried out to confirm the staff member's suitability to work with vulnerable adults before they started work. The Disclosure and Barring Service carry out a criminal record and barring checks on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions.

References had been obtained including, where possible, one from the last employer. The registered manager told us any gaps in potential staff's employment history were discussed at interview to determine their suitability to work in the service and however we saw this had not happened in all cases.

Staff told us people who used the service were also involved in the interview process for new staff and one person confirmed this with us.

We asked staff what they would do in the event of a medical emergency when providing care and support for people who used the service. We found 74% of staff were up to date with their first aid training and other training was to be booked to ensure compliance within 2016. The staff told us in the event of a medical

emergency an ambulance would be called, and they would follow the emergency operator instructions until an ambulance arrived. Staff we spoke with were aware of emergency protocols for peoples specialist needs such as epilepsy. One person we spoke with was really pleased that when they had choked on some food, staff had the skills to intervene. They said "They saved my life and I said thank you to them."

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with had in depth knowledge of how they supported people to make their own decisions and how they made sure decisions made on behalf of people were the least restrictive possible. We saw staff offering people choice and gaining consent before they delivered support to people. Staff had very good knowledge of people's communication where people were unable to use verbal communication, and staff understood what people's choices were from nonverbal communication.

We saw in some people's care and support plans the Mental Capacity Act (2005) had been used to make complex decisions. For example a person had been invited to attend a health screening appointment and staff had used accessible information, involved families and professionals to help understand if the person had capacity to make their own decision. The assessment of the person's capacity determined the person did not have capacity and a team of people which included the person's family made a decision in the person's best interest and this was recorded fully. Staff also told us how they had used advocates to support decision making for people where they had no family.

The service had participated in a project alongside Leeds local authority to determine people's capacity in relation to where they lived and their care and treatment. The outcome of these capacity assessments were documented in people's care and support plans.

The operations manager had led care and support plan review in January 2016.The review identified that despite a comprehensive amount of work completed around the Mental Capacity Act (2005), not all care and support plans contained the evidence of assessment and best interest decisions where required. This was something we also found in the care and support plans we looked at, we saw that not all decisions specific assessments were recorded appropriately for each person where required. At the time of the inspection the operations manager was producing an action plan from the care and support plan review to show how they planned to improve this area.

People told us they were confident staff had the skills and knowledge to support people with their specific needs. One person told us, "Staff have enough training, moving and handling and first aid, I have never had any accidents. I feel safe." Two visiting professionals told us staff used their specialist knowledge well, and this ensured people benefited from interventions such as support with their posture and communication.

We looked at records of staff training. The operations manager told us they are expected to reach 90% compliance for staff training in all topics which the provider told us were mandatory. The information we were shown showed us some topics of training such as food safety and infection control fell below 90%

compliance Food safety was at 64% and infection control 69%.

The operations manager had already noted this and had met with the house managers to discuss how compliance could improve. As a team they had agreed to reach their target by the end of 2016. They had also received feedback from staff that some of the current training delivered was not specific to their type of service. The operations manager told us they had begun to look at this to make training more specific to the service.

Staff we spoke with during the inspection told us on the commencement of their employment they undertook a full induction. This included reading policies and procedures and shadowing other experienced staff whilst they provided care and support to people. This helped to ensure people were supported by skilled and experienced staff.
Staff told us the quality of the training was good and provided them with the skills and knowledge to do their job. One staff member told us "There is plenty of training, positive behaviour support and safeguarding. In my supervision and appraisal I was asked if I wanted more and I chose Makaton and I have done this. They (Provider) will organise what is needed."

Staff we spoke with told us they had regular supervision and records confirmed this, however not all staff had received an appraisal. We spoke with two house managers and the operations manager who told us the provider's policy on supervision was not achievable or effective for the type of service they were managing. They had developed a project group and involved staff members to seek feedback on what effective support feels and looks like. The house managers showed us their plan which involved staff being supported through one to one meetings, staff meetings and appraisal over a 12 month period. They felt this would provide the right balance of support for staff. The house managers and operations manager were due to seek approval for this policy change and implement it as soon as possible.

The service provided support to people at meal times. Those people who were able were encouraged to be independent in meal preparation, and we saw people making their own meals both independently and with staff or peer support. Staff encouraged and supported people to have meals of their choice and we were told how people chose the menu for the week together in each service and did their own shopping weekly. One person said "The house shop we take it in turns and sometimes we do it with staff, I also cook with help from the staff."

We saw where people had more complex physical disabilities adapted equipment was being used to maintain their independence with eating and meal preparation
One person told us how they were proud to have won a weight loss sticker at the local slimming world. Staff told us how they were supporting this person to choose healthy recipes and make them from the slimming world magazine.

People's nutrition was monitored and where needed a dietician was involved or speech and language therapist. However the service did not use recognised tools to monitor people's weight and risk of malnutrition where required; they used their own knowledge and judgement. The operations manager told us they would start to use a recognised tool to monitor peoples nutrition which would direct staff more clearly when to refer to a professional.

People who required specialist diets for health conditions such as diabetes were supported to make decisions about food choices. We saw some people had their nutrition through a percutaneous endoscopic gastrostomy (PEG) which is a tube where food and drink is delivered directly into a person's stomach to ensure they have the correct nutrition and hydration. We saw people had an appropriate assessment from

the dietician and people were monitored by the staff and dietician. We saw a good example of how to record a person's food and fluid intake in one service. The house manager told us they would share this with colleagues.

The house managers and staff we spoke with told us they worked with other healthcare professionals to support people. A visiting professional told us "The service has good established links with primary and secondary health services and utilises full multi-disciplinary involvement to assess needs of individuals and source appropriate resources to support complex health needs in a timely fashions." Other visiting professionals also gave similar feedback.

A family member told us "If the staff are worried about their health they call people and I am happy with the outcome. They can judge their health well."

We saw in one person's care and support plan they spent time each day using a postural support system. This is a key area of support to maintain balance and strength in the person's upper body. The person did not always want to stay for the time recommended and so staff had recorded how best to promote the person did stay as long as possible, for example they suggested putting on a DVD or singing with the person.

Some staff had recently taken part in a postural management programme of training to become staff champions in the team for advice and support. Staff had also introduced a 'one page postural profile' for people so all staff knew the key support tasks to maintain the person's mobility and independence.

We saw the service used a document called 'Red, Amber, Green' which recorded the essential information about how to support a person if they were taken to hospital for the staff in hospital to use. This meant people with more complex communication needs were more likely to receive person centred support in hospital to meet these needs.

We saw in people's care and support plans that health appointments were recorded in different ways. In some systems it was difficult to navigate to the last appointment record to know what advice or action needed to be taken because it was recorded within people's daily notes. Where the health records for a person were recorded separately it was much easier to see people had received appropriate healthcare support. The operations manager told us they would use this feedback to arrange for the best practice to be implemented consistently.

Good

Is the service caring?

Our findings

All of the people we spoke with were complimentary about the care and service they received. One person said, "Staff are very caring. I won't ask for a better team. They seem to understand when I am poorly." Other people said "This team is so good. I am lucky to have them in my life. They make me so happy."

Family members confirmed they were happy. One family member said "I am really really happy. It is so much better than the previous service. Staff are professional and friendly, very helpful and it is homely and very welcoming." Another family member said "I am definitely happy. We visit regularly and take my relative out and they are always clean shaven and well presented. They go on holiday and I am kept up to date." Also "I am constantly amazed at the work they [staff members] do; they are devoted. I couldn't ask for a better group of staff."

Visiting professionals also told us the staff members were caring in their roles. One professional said "I feel the people living there are very well supported by staff who really care, in a very person centred way." Another said of the staff, "I can state that the best staff I have met in my career, who have demonstrated the best person centred care, and seemed to embody and enact the best care values, have all worked in the specialised supported living service." Two of the visiting professionals told us they would recommend the service to their own families because they felt the service was good.

Many of the staff told us they enjoyed their role so much because they were able to see the difference they made in people's lives as they gave quality of life to people. One staff member said "The best thing is getting to see people enjoy a fulfilled life, seeing their skills improve and become more independent."

We saw staff work in a person centred way during our visit. Person centred means putting the individual's choices, preferences and wishes at the focus of everything staff do so people receive the support they want and how they like it. For example we saw one person who communicated through body language and behaviour. They tapped their cup on the side of the table and staff knew instantly the person had finished their drink and would like to move to another activity. We saw another staff member supporting a person following their shower. They brought them into the kitchen to bring their laundry and then offered to blow dry their hair which was their preference following a shower.

Care files contained information about people's life history and preferences. This gave important information about people's background and their likes and dislikes. This information helped staff to provide more personalised care. People and their families told us they were fully involved in assessment and review. One person said "I helped fill in the 'All about me' when I moved in."

We saw people had a 'one page profile' in their care and support plan which tells staff how they would like to be supported and what people liked and admired about them. One person's profile said they enjoyed music and when we arrived at their home the person was sitting in their lounge listening to their favourite music.

We also saw a document called 'My expectations of staff' which outlined how staff should behave in the person's home. One of the items was 'Staff to leave their coat and bag under the stairs', the person confirmed staff were respectful and they did this all the time.

Staff spoke with kindness and compassion and were highly committed and positive about the people they supported. Staff knew and understood the individual needs of each person, what their likes and dislikes were, and how best to communicate with them so they could be empowered to make choices and decisions. For example, we saw one person had hair over their eyes. Staff noted this and asked if they would like a hair clip. The staff member returned with various options, and took time to ensure the person picked which hair clip they wanted to wear.

It was clear from our discussions with staff and our observations that the values of privacy and dignity underpinned the work staff carried out with people. For example staff had sourced window screens to protect a person's privacy in their bedroom. We saw staff discreetly ask people if they would like support. People we spoke to confirmed this. One person said "Staff listen to me with what I have got on my mind and they always shut the blinds when I get dressed."

People's diversity, values and human rights were respected. Staff told us of the importance of encouraging independence. We were told how technology was used to support people to communicate, for example by using an iPad to ask for help. We saw in one service how ingredients for breakfast were placed into smaller containers so the person could hold them, which meant they were able to serve their own cereal.

Staff told us how they had broken down each step of travelling on the bus to small steps to learn until the person became confident and successful. One person told us "I am independent and go out alone, I balance time with staff and time alone, I go out swimming and to the gym. How I use travel was done through travel training." Another person told us how they now spend time alone in their home, and because of this approach they knew to ask for identification if a stranger came to their front door.

Good

Is the service responsive?

Our findings

People and family members we spoke with during the inspection told us staff knew them well and were responsive to their needs. One person said, "Moving here was the best decision I ever made."

During our visit we reviewed the care and support records of nine people who used the service. We saw people and their family members had been involved in the development of their care and support plans. Each person had a range of care and support plans to meet their needs. Information within them was person centred to ensure people's preferences were recorded. The format used included headings such as 'The outcome I want', 'How I was involved' and 'Please remember these things when supporting me, they are important to me'. This meant the information was focused on the person receiving support in the way they wanted. For example, in one person's plan it said they needed time to communicate when staff asked them a question. We observed on the day we visited staff waiting for the person to respond and re-phrasing their question to help the person understand.

Each person had a 'Named person' in the staff team whose responsibility it was to ensure care and support plans were reviewed regularly. We saw in one service a good example of a person centred quarterly review document which included what was working and what was not working for the person, and made plans for the coming months in relation to health, activities and goals. One particular goal was for the person to seek tickets for the 'Spice Girls' world tour if the band reforms because that was a dream for the person. Staff checked internet entertainment news monthly to ensure they did not miss the opportunity should it arise.

We were told this type of person centred planning was something the staff team across the services had learnt about to help make sure people had fulfilled lives. We did not see records of this happening as well in all services. The good practice was something the operations manager told us they would share with house managers to be used in all services in the future.

We saw staff responded to people's needs by listening and observing people's behaviour. For example one person wanted to know which staff were working, and to help them understand and remember staff faces each staff had a fridge magnet in the kitchen with their picture. We saw staff identify with the person who would next be on shift. This supported the person to feel empowered and less anxious.

We were told by staff members one person had recently chaired their own review meeting and the person confirmed this and told us they were proud they had succeeded.

We saw people had very personalised bedrooms. One bedroom had signs of the person's religion and staff told us they supported the person to access religious venues. One person told us they liked fresh flowers each week for their own room and we saw them in vase when we visited. Staff had worked with another person to decorate their room with a theme park mural of a roller coaster; the person was really pleased to show us the end result.

The range of activities people, their families and staff could tell us about was extremely varied. We saw

photographs of people with physical disabilities visiting the local climbing wall. People told us they loved going to the tiger tiger nightclub. People had attended the Normanton festival and tickets to see the 'red hot chilli peppers' were booked for the Leeds festival.

A family member told us how staff supported them to meet their relative for lunch each month which they really appreciated. People who were religious were supported to attend church.

Where people had physical disabilities regular hydrotherapy sessions were organised and staff had sourced different pools so people attended the best in the area. Staff also told us how they supported a person to access 'Love to meet you' dating service because the person had asked for this.

We saw people were fully involved in their home from choosing the decoration and ornaments, to polishing and washing up. One person had recently bought a garden fountain which was solar powered and we saw them sitting by the window hoping for sunshine to see it working.

Holidays were a big topic of discussion in all the services we visited. People were excited waiting for their next holiday and told us they often go twice a year. Places had been visited such as Ibiza, Blackpool, London and Majorca. Staff took time to research the facilities for people with physical disabilities to ensure they were accessible. On the day of our visit to one service a person was fitting in a trip to Bridlington to have fish and chips for lunch.

People also regularly attended places where they saw friends such as the local youth club, arts clubs, and sports venues. One person had a Leeds Rhinos season ticket and was excited about going to Wembley in August 2016 to see the rugby league final; they said "Whoever gets there."

Some people had volunteer roles and attended college. People told us they hope to improve their skills for the future.

We saw records did not always reflect the activities people were involved in to enable the teams to understand if people had a fulfilled quality life or not. We saw positive interactions and activities during our visit. Staff told us what activities people took part in, as did the people who used the service and their families. One house manager told us how positive behaviour support training had recently triggered people thinking about 'What I did today' to help assess peoples quality of life. The operations manager told us this was an area the new positive behaviour support training would help with in the future.

One family told us how staff had worked with them since their relative moved to the service to plan an overnight visit to their home. Staff would be supporting the person alongside family on the first visit because the person's needs had changed since the last visit. The family were appreciative of the support from the service and excited about their relatives visit.

The operations manager told us the service had received one complaint in the last 12 months. We saw this compliant had been fully investigated. We looked at the complaints procedure, which informed people how and whom to make a complaint to. People also had an easy read version which used symbols and pictures for people to understand the process to follow if they had concerns.

One person told us "To complain I would tell staff here or the person supporting me." A family member said "I do know how to complain but I can't imagine that would happen."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had moved to a new role with the provider, which meant they no longer had day to day oversight of this service. The operations manager told us they had applied to de-register from this role. The operations manager in post told us they were in the process of applying to be the registered manager of the service.
We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their services.

We found there was not a robust quality assurance system which checked all areas of service delivery to ensure they were safe and effective. The provider did not have a robust audit for the operations manager to complete to ensure quality and safety in services. Information available to the provider around compliance with procedure in areas such as training, staff meetings, staff supervisions, and review of hazard risk assessments, were not used in measuring the performance of each service. The provider had not taken action to address differences in performance across the services.

The operations manager did complete an annual health and safety check and we saw issues had been identified, but there were no records to show action had been taken. We saw that no checks were made in areas such as medicines. We found issues with medications that the provider was not aware of because of the lack of audit in place.
The provider did not ensure consistency of approach across all the services. For example; in one service the house manager completed staff meetings more frequently than in others. A visiting professional also told us they had noticed variations across the services which they felt impacted on effectiveness of the service. This meant quality and safety in each service was different and there was therefore a risk of people receiving poor quality care.

We saw that the house managers had completed a care plan audit in January 2016. In July 2016 the provider completed a detailed summary of their analysis of the findings. The audit highlighted similar areas to those found during this inspection. The operations manager was preparing an action plan to improve the service but this had not yet been communicated to house managers.

The operations manager had used recognised person centred tools to assess the progress of the whole service annually through speaking to people, staff and the house managers. One tool we saw was 'progress for providers'. The outcome of this process was that people wanted more say in how the service was run and that the service needs to find ways to measure the effectiveness of how they support people.

We were told by the operations manager a new system called Datix had been implemented across the provider's service but not the specialist supported living service. This meant the house managers and operations manager no longer received feedback from the provider on trends in accidents and incidents. This meant issues could be missed because the data was not being routinely analysed and people therefore may not receive changes in support which may have been required to minimise the risk of recurrence.

The operations manager told us the Datix system being introduced in the specialist supported living service was planned. Following the inspection they told us a formal plan had been devised for this to happen in 2016.

The provider is legally responsible to report all safeguarding concerns to the NHS reporting mechanism. We looked at the data held locally and cross referenced this to the NHS report of all incidences reported. We found that five incidences were not reported. Then provider immediately looked at how this had happened and changed the system in place to ensure this did not happen again. The operations manager told us once the Datix system is introduced, reporting errors will not happen.

This was a breach of Regulation 17 (Good governance); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and family members we spoke with during the inspection spoke highly of the house managers and registered provider. They told us they thought the service was well led. One person said, "We have a good house manager." Another person said "Our manager is brilliant, very supportive and very thorough."
From discussion with staff we found the operations manager and house managers working together gave them effective role models and this resulted in strong teamwork, with a clear focus on working together. One staff member we spoke with said, "I feel valued and listened to." Some staff told us they received praise and celebrated good practice in their service. However, others said this rarely happened.

We found there was a culture of openness and support for all staff involved throughout the service. Staff told us they were confident of the whistleblowing procedures and would have no hesitation in following these should they have any concerns about the quality of the provision.

Visiting professionals told us that they noticed the positive communication between people supported, staff and the house managers which they felt was good.
Staff told us they were kept up to date with matters which affected them. We saw records to confirm staff meetings took place but the frequency was different across the services. The operations manager also held monthly meetings for the house managers to keep everyone up to date on policy change and legislation updates. We saw the minutes contained agenda items such as complaints and duty of candour.

The operations manager had also included people who used the service and staff in a new governance meeting. The purpose of this meeting was to analyses patterns and trends in incidents and outcomes from the services to put in place actions to improve. We saw minutes from recent meetings where the reason for the group and how they wanted to operate the group was being decided.

All the people we spoke with told us about a staff member who visited and asked them for feedback on the service each year. We saw the results from the last survey were recorded in the annual report for the service, the results were positive and where areas to improve were identified the service had taken action to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was not safe and proper management of medicines. Regulation 12 (1), (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not assessing, monitoring and improving the quality and safety of the service robustly. Information was not always evaluated and used to improve the service. The system for reporting safeguarding concerns did not ensure all incidences were recorded robustly within the required reporting process. Regulation 17 (1), (2) (a), (b), (f)