

Independent Lives (Disability)

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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?	Requires Improvement ●

Summary of findings

Overall summary

We carried out a comprehensive inspection of Independent Lives (Disability) on 19 and 21 December 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides support to adults across the whole population. At the time of the inspection 52 people were using the service.

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

The service was last inspected on 16 and 18 February 2016 and was rated 'Good'. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns.

At the last inspection on 16 and 18 February 2016, we asked the provider to take action to make improvements as we found people did not always have safe and proper support with their medicines. At this inspection we checked to see if the provider had taken actions to address these issues and found that they had and people were receiving safe support with their medicines.

The service had systems and processes in place to encourage and enable accessible and open communication with people who used and were connected to the service. However, many people we spoke with said that communication was not very good and they felt their views and experiences were not always acted on to improve the service. This is an area of practice in need of improvement.

The service had sufficient staff and people's needs were being met but some people told us care calls did not always take place at their preferred times. The service was aware of this and had invested in resources to improve the service in this respect.

There was a complaints policy in place and people told us they knew how to raise a complaint and felt confident to do so. Some people felt like complaints were not dealt with properly and issues were not resolved. The service aimed to resolve all complaints to everyone's satisfaction. The service was open and transparent and offered apologies when people had made complaints.

There were safe recruitment practices and systems and processes in place to keep people safe from abuse. Accidents or incidents which were responded to quickly to put actions into place to keep people safe. The registered manager reported incidents and accidents onto other relevant partner agencies for review and agree any necessary actions to keep people safe.

The organisation had an Equality and Diversity policy in place. Staff also received training to help them understand the importance of recognising and preventing discriminatory abuse against people and supported people to understand their rights. People, equipment and people's homes had risk assessments in place to keep people safe. The service ensured that people were involved in this process and restrictions on their independence were minimised.

Staff received infection control training and used Personal Protective Equipment (PPE) when supporting people with personal care tasks. Any hazardous waste was managed correctly. Staff had received food hygiene training to safely support people with any food preparation and handling support.

Staff received Mental Capacity Act 2005 (MCA) training and understood the relevant consent and decision-making requirements of this legislation. People or a relevant person acting in their best interests had signed their support plans to say they consented to their care. People were involved in regular reviews of their support and could see their care plans whenever they wanted.

Staff had regular training and updates to be able to have the right skills and knowledge to be able to meet people's assessed needs. Staff had regular spot checks, supervisions and appraisals to help them to understand their roles and responsibilities.

The service assessed people's physical, psychological and social needs to ensure they were able to meet their preferred support outcomes. Where appropriate family members and other relevant people were also involved to make sure people got the support they wanted and needed. Staff respected and did not discriminate when people had a support need or made a particular decision related to their protected characteristics under the Equality Act 2010.

The service used technology to enhance the delivery of effective care. People's care plans contained details of any medical and health care support needs. If necessary, staff would support people to access healthcare services. People had effective support to eat and drink and maintain a balanced diet.

People told us staff were caring and they felt involved in their care. Staff supported people in a kind and compassionate manner. People's care plans contained information about their personal life histories to help staff quickly get to know about who a person was as an individual. People's privacy and dignity was respected and they were encouraged to be as independent as possible when having support.

People's personal information was treated confidentially in line with the principles of the Data Protection Act. People contributed to the planning of their care and support. People's care plans included information about what was important to them that staff needed to know and do when supporting them.

People's care plans identified how to meet the communication needs of people with a disability or sensory loss. The service ensured the accessibility of information about care and support for people with a disability or sensory loss related communication need.

There was a clear vision and set of values in place to deliver high quality and person centred care to people. There were management processes to outline expectations for staff responsibility and accountability. There was positive, supportive, inclusive and open team culture. Promotion of staff well-being and equality and diversity rights were a priority. Staff felt respected and involved in developing the service.

There were quality assurance and information governance systems in place to monitor the quality and safety of the service. Actions for improvement or areas of success to build on were identified and carried out

in a timely manner.

The registered manager had submitted notifications to the Care Quality Commission (CQC) regarding all notifiable events that had occurred at the service and demonstrated their awareness of the Duty of Candour CQC regulation. The service shared information and worked in partnership with the local authority, police and healthcare professionals to implement actions and improvements in response to any notifiable incidents.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service has improved to good.	Good ●
Is the service effective? The service remains good.	Good ●
Is the service caring? The service remains good.	Good ●
Is the service responsive? The service remains good.	Good ●
Is the service well-led? The service has deteriorated to requires improvement.	Requires Improvement ●

Independent Lives (Disability)

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.

This inspection took place on 19 and 21 December 2017 and was announced. We gave 48 hours' notice of the inspection to allow enough time for the provider to arrange for us to visit people in their own homes on the day of the inspection.

The inspection team consisted of an inspector. An assistant inspector also made telephone calls to speak to people using the service.

We did not ask the provider to complete to a Provider Information Return (PIR) prior to this inspection, this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law.

During the inspection, we visited two people in their homes to talk with them and observe their care. We spoke with seven people who use service on the telephone. We spoke with two relatives, five staff members and the registered manager.

We reviewed care records for four people and 'pathway tracked' them to understand how their care was

being delivered in line with this.

We reviewed staff training, supervision and recruitment records, medicines records, care plans, risk assessments, and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas, information about activities and other records related to the management of the service.

Is the service safe?

Our findings

People we visited in their homes and most of the people we spoke with on the telephone told us they felt safe. We found the service was operating safely but care calls did not always take place at people's preferred times.

Everyone told us that there had been a lot of issues with the service in the past with not enough staff meaning staff would not turn up to calls or would be late. People and staff told us there was now enough staff so calls were not being missed but calls could still be regularly late. Some people told us staff did not always let them know in advance if their calls were going to be late. Everyone we spoke with said although currently their needs were eventually met, late calls were inconvenient and caused people anxiety- especially if people were not given advance warning.

The registered manager acknowledged calls had been missed or late in the past due to under-recruitment and care co-ordinating issues. We were told, "That was very difficult but people were never at risk". The provider had taken steps to resolve the issues. They had now recruited enough staff and reviewed their care co-ordination systems.

There was a new electronic monitoring system which logged when and where staff arrived and left calls. If staff were running late for their next call, the system sent an automatic alert so the office could ring people to let them know in advance there might be a delay. If the system showed a call was consistently late the management would be made aware straight away and could immediately monitor and review to resolve the issue. The system "locked" non-flexible calls, for example for people who required medication at a specific time. This meant care co-ordinators scheduled these calls as a priority and staff knew they must arrive on time. We sampled electronic call logs which showed us how people with priority care needs had consistently received their calls on time.

We discussed other reasons why people were telling us their calls were late. We were told that people with non-priority support needs had a preferred call time but their care agreements contained the understanding this could be subject to delays. Staff told us travel time was built into their rotas but sometimes delays were unavoidable due to traffic or other calls running later than planned. The registered manager was aware that not having calls at the preferred time was far from ideal but was confident that the new systems would help to improve their practice in this area.

There were safe recruitment practices. All staff had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. In addition, all staff also had to submit an application form, supply two references, a full employment history and complete a successful competency based interview before they started work.

Staff completed daily electronic notes and specific report forms that detailed any accidents or incidents which were immediately passed onto management. Staff told us the registered manager and senior staff

always responded very quickly to put actions into place to keep people safe. The registered manager regularly reviewed and communicated outcomes and learning with staff following accidents and incidents to help prevent these from occurring in the future. The registered manager reported incidents and accidents onto other relevant partner agencies such as the local authority or the Care Quality Commission (CQC) for review and to agree any necessary actions to keep people safe.

There were systems and processes in place to keep people safe from abuse. Staff had received safeguarding training and understood their responsibilities to recognise signs of abuse and stop or prevent this. Some staff were 'Safeguarding Champions' with specific monitoring and reporting responsibilities. Any concerns of abuse were recorded and reported to senior staff or management who took necessary action to help keep the people safe. The registered manager was part of a multi-disciplinary team safeguarding panel alongside the local authority, district nursing team and the police. The panel used information from safeguarding incidents to look for common themes in abuse incidents and then pool resources to help prevent the situations re-occurring. For example, sending a mailshot to vulnerable adults to advise them of potential abuse situation and what they could do to recognise this and how they could get help.

The organisation had an Equality and Diversity policy in place. Staff also received training to help them understand the importance of recognising and preventing discriminatory abuse against people. One staff member told us, "You treat everyone equally and respect their beliefs and who they are as a person". The organisation was part of the 'Worthing & Costal Action Group' arm of the West Sussex 'Involvement Network'. This group facilitated disabled people using the service to have a platform to have a say and become involved in issues affecting them in the local area. For example, people said accessible transport was an issue as many local taxi firms would not pick up disabled people. The service had offered to invite owners of taxi firms to a meeting and arrange trips to their firms to challenge assumptions about it being more difficult for disabled people to get into cars and to help them feel more confident to do this.

People had risk assessments in place that identified any potential hazards to their well-being, the risks this presented and the control measures needed. Staff used the information from the risk assessments to provide the right support to keep people safe. Risk assessments were undertaken to make sure people's homes were safe to work in. There were risk assessments for operating any equipment people needed for their support. The service ensured that people were involved in this process and restrictions on their independence were minimised. For example, staff had been trained to use a hoist that had been installed for a person who would not be safe to get up from bed otherwise. This allowed the person to remain living in their own home with their husband as they wished.

At the last inspection on 16 and 18 February 2016, we asked the provider to take action to make improvements as we found people did always have safe and proper support with their medicines. At this inspection we checked to see if the provider had taken actions to address these issues and found that they had.

The provider had implemented an electronic Medication Administration Record (MAR) system which included information about the person and the medicines they needed, including details about how their medicines should be taken or used and how often. Staff inputted an electronic signature to show people had taken their medicines. If staff attempted to leave a call without signing the MAR, the system would automatically send an alert to prompt them to do so. This helped minimise the risk of people not receiving their medicines on time or as intended. Some people were prescribed medicines on a 'when required' (PRN) basis if they needed them. There was PRN guidance in place describing the requirements for when staff should offer and administer PRN medicines for people. We observed staff following PRN guidance and supporting people with medicines in a caring and hygienic manner.

Staff received infection control training and we observed Personal Protective Equipment (PPE) was available in people's homes, which staff used when supporting people with personal care tasks. We saw suitable bags, containers and disposal equipment was available and in use by staff when supporting people to manage any hazardous waste. Staff had received food hygiene training to know how to safely support people with any food preparation and handling support they needed.

Is the service effective?

Our findings

People we visited in their homes and most of the people we spoke with on the telephone told us the service was effective and they had support to achieve good outcomes and quality of life.

The Mental Capacity Act (MCA) 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. We checked to see if the service was operating within the principles of the MCA and found that it was.

Staff received MCA training and understood the relevant consent and decision-making requirements of this legislation. If applicable, people had an assessment in their care plans of their mental capacity to be able to make decisions about different activities. We saw people or a relevant person acting in their best interests had signed their support plans to say they consented to their care. People were involved in regular reviews of their support and could see their care plans whenever they wanted.

Staff had regular training and updates to be able to have the right skills and knowledge to be able to meet people's assessed needs. Staff received an induction that met the Care Certificate standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

Staff could request specific training to meet people's individual needs. One staff member told us how they had requested and completed mental health awareness training to be able to better understand and support someone whose support needs had changed. The organisation had an in-house training team, including clinical Nurses, who helped share information and deliver staff training based on the most up to date professional practice and knowledge. In addition to training, staff had regular spot checks, supervisions and appraisals to help them to understand their roles and responsibilities.

The registered manager or senior staff completed a thorough assessment of people's physical, psychological and social needs to ensure they were able to meet their preferred support outcomes. The registered manager told us assessments were designed to be primarily led by the person saying, "We learn about customers through their input". However, they recognised it was also important that where appropriate family members, health and social care professionals and other relevant people were also involved to share information and make sure people got the support they wanted and needed.

Relevant professional guidance was obtained by the registered managers when assessing people's needs, to ensure the right support was put in place. For example, one person required support to take food, fluids and medication via a percutaneous endoscopic gastrostomy (PEG) tube. All staff had received training from the organisations' in-house clinical Nurse training team on how to do this and relevant clinical guidance had been obtained and was in place to direct staff how to use the PEG equipment.

Staff respected and did not discriminate when people had a support need or made a particular decision related to their protected characteristics under the Equality Act 2010. For example, staff told us about supporting a person who practiced a certain religion saying, "We make sure we do things the way they want them done". Another staff member told us, "Some people we support are religious. I am not religious but I listen and respect this. I make sure they know they can talk me about their faith".

The service had recently introduced an electronic system that centrally stored information about people's care and support needs. People, their relatives and senior staff and management could all access this information remotely. The system allowed real time updates of people's care plans and care notes. Staff recorded the latest care information for a person via a mobile electronic device during each call. This was then immediately available to view for everyone who had access to the system. Staff told us this was useful in enhancing the delivery of effective care as they could see the latest up to date information about people's care right away. For example, if a person's needs had changed following a visit from a district nurse in a morning call, the staff making the afternoon call would know about the change and be able to prepare in advance.

People's care plans contained details of any medical and health care support needs. If necessary staff would support people to access healthcare services, either by helping to make appointments and reminding people of when these were or by accompanying them if necessary. Staff told us of the importance of being aware, recognising and acting to encourage or facilitating people to get access to further support if they had concerns about a person's health or well-being. The registered manager showed us information resources they had given staff to be able to do this effectively.

Where necessary, people had effective support to eat and drink and maintain a balanced diet. People's care plans recorded any eating and drinking support needs. Where people had complex eating and drinking needs this was recorded and staff followed any specialist guidelines to support them effectively. The electronic care plan system had features that built graphs showing the correct ratios of different food groups to create nutritionally balanced meals to support staff and people to plan and provide healthy menus.

Is the service caring?

Our findings

People told us they thought staff were caring. One person said, "Some staff are lovely and kind". A relative told us staff were, "Very good with my husband, they are always cheerful". Another relative told us staff were, "Nice and friendly".

People told us they felt involved in their care. Staff told us it was important that people felt they were being treated in a caring manner and made to feel that they mattered. One staff member told us, "You can't do care work without being caring". We observed staff supporting people in a kind and compassionate manner, making sure they were involving and including people in what they were doing. Staff asked permission and talked through the support they were offering people using reassuring tones of voice and appropriate language. We saw staff listened to people and made small adjustments to their support in response to what they were saying to make them feel more comfortable.

Staff took into account any protected and other characteristics under the Equality Act 2010 when considering how to communicate in the most accessible way for people. People who were vision impaired were read letters and other printed materials aloud or had support to use vision aids, such as magnifying glasses, to be able to read. Staff had requested and been trained to use British Sign Language to be able to communicate with people who were hearing impaired.

People's care plans contained information about their personal life histories. Staff told us although they always tried to take time to have a cup of tea and a chat with people, the amount of time they spent on each call was limited. Staff also did not always support the same people regularly. This meant it could take time to get to know people, so the information in the care plans was helpful for them to quickly get to know about who a person was as an individual. Staff told us this knowledge was important as it helped to relax people and make them feel at ease if they could initiate conversations with people about their backgrounds and past achievements.

People told us they felt staff respected their privacy and dignity. People's preference for only receiving intimate care support from staff of a particular gender was respected. Staff we spoke with understood the importance of promoting people's dignity and treating them with respect at all times. People's care plans detailed any concerns they had and the impact of this, so staff knew how to support their emotional well-being. People told us they were encouraged to be as independent as possible when having support. One person told us how they had help to know how to use a microwave so they could remain having minimal support with preparing meals.

People's care plans contained a 'Privacy Statement' that both they and the registered manager had signed. The statement complied with the principles of the Data Protection Act and explained why people's persons' personal information was collected and kept by the organisation, what was done with it and who else could see it. Staff we spoke with understood their responsibilities to maintain people's confidentiality. There were information governance, data release, customer confidentiality and IT security and acceptable use policies

in place to protect people's personal information. The registered manager told us how the electronic care notes system was encrypted and there were strict data protection controls to ensure that only people with the right security clearance could access people's personal information on the system.

Is the service responsive?

Our findings

People we visited in their homes and most of the people we spoke with on the telephone told us the service was responsive and met their needs.

There was a complaints policy in place and people told us they knew how to raise a complaint and felt confident to do so. We received mixed feedback from people about how the service responded to complaints. Some people told us they were happy with the response they got if they had raised a complaint. Other people felt like complaints were not dealt with properly and issues were not resolved. Staff told us they had invited people to make complaints if they were unhappy but that it was "Never anything major" and that "People seem satisfied" with the responses.

The registered manager told us the service worked hard to resolve all complaints to everyone's satisfaction. We saw records showing all complaints received were logged centrally and reviewed by senior management every month to look at how they could learn to prevent them from re-occurring. Staff told us complaints were discussed between seniors, managers and the registered manager. We saw a formal complaint response from the registered manager in which they had been open and transparent and offered an apology for any shortcomings on the service's behalf.

Everyone told us they had contributed to the planning of their care and support. A person told us they were "Quite satisfied" they had been involved in personalising their care when it was being planned. If appropriate people's relatives, or other people with relevant authority, were involved with planning people's care on their behalf. A relative explained how they had been visited several times by senior staff to plan their husband's care before he had started receiving support and that, "Plans were shared with me as soon as they were written". Another relative told us they were, "Always involved".

People and their relatives had regular 'Customer Reviews' with staff. The reviews confirmed if there had been any physical, mental and emotional or environmental changes to people. This allowed to staff make any necessary changes to people's support so it met their most recent levels of strengths and independence. One person told us how their care needs had evolved and they had suddenly needed significantly more complex support with eating and drinking. The service had responded promptly and made the necessary changes to enable them to do this while remaining living at home. This had allowed the person to maintain the relationships with his wife and daughter in an environment that provided them with the best possible quality of life.

People's care plans included information about what was important to them that staff needed to know and do when supporting them. This included knowing about people's routines, things they liked to do, important places and events in their lives, social and personal relationship networks and religious and cultural preferences. This information was used by staff to ensure they were always respecting people's choices and really understood the personal context behind people's likes and dislikes.

We sampled people's plans and found some plans contained more detail than others. Staff told us plans

were regularly being updated, adding, "There are details in people's plans, some do have a lot of person centred information". Staff explained they knew people well and often spoke with other staff and family members be sure they understood how to best support people. People's relatives confirmed they thought staff knew people well. One relative said, "They know who we are as people".

Staff updated the electronic system care notes and plans after each visit. As the information was accessible by family members and people straight away, they could immediately review this to confirm the support being offered, including any changes, accurately reflected their needs and preferences. If there were any issues or suggestions about the care being offered, these could be raised without delay. This meant people, and important people in their lives, were able to exercise greater control of the planning and delivery of their support.

All people using the service had a 'Social Inclusion Assessment' which was designed to consider the risk to people of social isolation. The assessment ascertained the level of support people might need to maintain or develop relationships and to access any social activities. If people were at risk of becoming isolated, the service could support them to avoid this. People were also encouraged to drop into the service office at any point outside of their allocated support to talk to staff and meet up with other people using the service. During our inspection a person came into the office for a cup of tea and a chat with staff and valued the social interaction this provided them.

People's care plans identified how to meet the communication needs of people with a disability or sensory loss. For example, one person who was verbally impaired had a communication plan that provided details of how they communicated with others and needed others to communicate with them so they could interact with people, be understood and make appropriate choices.

The registered manager was aware of the Accessible Information Standards (AIS) and the service ensured the accessibility of information about care and support for people with a disability or sensory loss related communication need. People who were hearing impaired could receive information about their support via a text phone. The service also issued large print rotas and other written correspondence for people who were vision impaired. For people with an intellectual disability, there were 'Easy Read' versions of information about care and support.

The service website included a feature that increased the font size of text for people who were vision impaired as well as having easy read sections. If people required an alternative version of their care plans or notes or other information about their support, the service could provide audio versions or have staff verbally explain them. If people with communication needs' first language was not English, the alternative formats and methods could be provided in their preferred language.

Is the service well-led?

Our findings

People we visited in their homes and people we spoke with on the telephone gave us mixed feedback about the leadership and governance of the service. Some people did not think the service was always well-led. We found that although overall there was evidence of good practice, communication between people and the service was an area of practice in need of improvement.

The service had systems and processes in place to encourage and enable accessible and open communication with people who used and were connected to the service. Digital and paper newsletters were sent to people every month and their website was regularly updated. The service had social media profiles to share information with people, including their comments and suggestions about what was and wasn't working. There were regular coffee mornings hosted at the service office where people could talk to staff face to face and say if they thought the service could improve. People and their relatives were sent annual surveys asking for feedback about the service performance and ideas about making it better.

However, many people we spoke with said that communication was not very good and they felt their views and experiences were not always acted on to improve the service. Several people told us they didn't receive any communication. Everyone said when they had repeatedly given feedback and asked for information to improve their service, such as having rotas sent to them in advance, this had not been done. One person said when they had done this they felt received a standard response and this, "made me feel fobbed off". A relative told us, "I don't get surveys". Some people said had not got or had not received any surveys ever. One person told us they had completed a survey but had not heard anything since then. A relative told us they had had completed one or two surveys but, "Never had a lot of feedback".

Although there were varied systems and processes in place to help involve and enable people in improving and developing the service, the consistency and volume of people's feedback stating they were not aware of these or did not find them effective indicates this is an area of practice in need of improvement.

The registered manager told us the vision of the service was to deliver support that enabled people to lead fulfilled lives and be as independent as possible. There were management processes to outline expectations for staff responsibility and accountability in achieving this vision. We saw records that confirmed values and the organisations' vision were discussed when evaluating staff performance during supervisions, appraisals and disciplinary and induction and probation procedures. Staff told us these were constructive and helpful. One staff said, "We know what we need to do for our jobs 100%. We have all got good values. We all respect each other and we respect the customers".

The registered manager promoted a positive, supportive, inclusive and open team culture. Staff received internal newsletters and there were staff meetings. Staff said the registered manager and senior staff were always visible and approachable and they felt involved in developing the service. One staff member said, "The management are open and will act on feedback. We are asked for feedback and this is taken on board. I can go and talk to any member of staff. I feel respected". There was a whistleblowing policy in place that

allowed staff to raise concerns confidentially at any time.

Staff well-being was a priority for the organisation. The registered manager said, "This not an easy job and staff need support, even if it is just to chat about their feelings and how their day has been". A staff member told us of how they had received emotional support with a non-work related issue and had adjustments to their working patterns while this was going on. The organisation had committed further resources to support staff to support their wellbeing and resilience in the work place by funding a free-to-attend 8 week mindfulness course for staff.

The registered manager told us respecting staff's equality and diversity was embedded in the organisations' values. The organisation was a Mindful Employer and Disability Confident scheme member and was committed to promoting positive awareness and respecting the equal rights of staff with disabilities or mental health conditions. We saw examples of where the service had made individually tailored reasonable adjustments to accommodate the effects of staff's disabilities in the workplace.

There were quality assurance and information governance systems in place to monitor the quality and safety of the service. Staff completed daily care notes electronically. Daily audits of people's notes took place by senior staff and registered managers. The system sent out an alert if support outcomes have not been met. The registered manager explained they would then call the support worker within minutes of them leaving the call to return and complete any outstanding tasks.

Quality assurance information about service performance from care notes and other information sources were compiled centrally onto a spreadsheet that was divided into 5 main areas, compliance, complaints, concerns, compliments and comments. The registered manager and other senior managers within the organisations audited this spreadsheet monthly. This identified any actions for improvement or areas of success to build on. These actions were added to an on-going development plan with timeframes for responses to each action. We sampled these spreadsheets and saw actions had been or were in the progress of being completed in a timely manner and that an evaluation of the actions effectiveness was also carried out for future learning.

Care homes and other health and social care services are required to notify the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check the action the service took and if necessary request additional information regarding about the event itself. The registered manager had submitted notifications to the CQC as required regarding all notifiable events that had occurred at the service.

The registered manager demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The registered manager had shared information openly with people and relatives when important events involving people at the service had taken place. We saw they had also shared information and worked in partnership with the local authority, police and healthcare professionals to implement actions and improvements in response to any notifiable incidents.