Cambridgeshire County Council

# Community Support Service

## Inspection report

Buttsgrove Centre
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Community Support Service is a service that is registered to provide personal care to children and younger people living in their own homes or support them in the community. The service supports these people to live more active and independent lives and provides respite for parents. This was for children and younger people living with a learning or physical disability or sensory impairment. At the time of our inspection there were 106 people using the service.

This inspection took place on 25, 26 and 29 February 2016 and was announced.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider had appointed a new manager but they had not yet taken up their position.

A robust recruitment procedure was in place and this had been adhered to. This helped ensure that staff were only recruited after all the required checks had been completed. People were cared for by a sufficient number of staff who were qualified to meet their needs.

Staff had been trained in medicines administration and they had been deemed competent to undertake this role. Safe medicines administration practice was adhered to.

Staff had received regular training and updates and were confident in their understanding of protecting people from harm. This included the identification of concerns and who these could be reported to including the registered manager and the local safe guarding authority.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Not all staff had been trained in this subject and some lacked any awareness of this Act. This put those younger people who were included in this legislation at risk of being provided with care that did not follow relevant guidance.

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. We checked whether the service was working within the principles of the MCA and whether any applications had been or needed to be submitted to the appropriate authorities. No person using the service had been identified as lacking mental capacity and therefore no applications were required to be submitted to the court of protection.

People's privacy, dignity and independence was supported by staff who showed compassion. Risk assessments were in place and staff followed these. This was for subjects such as supporting people out in the community, behaviours which could challenge others and medicines administration. Checks were in place to support people with their safety.

An in-depth assessment process was in place to help ensure that people received the care they wanted. People were involved in the process to determine their care needs with family members or health care professionals support.

People were supported to see or be seen by a wide range of health care professionals including a speech and language therapist, their GP or physiotherapist.

People were supported, when required, to eat and drink sufficient quantities People could choose to be as independent as they wanted with their eating and drinking.

Staff were provided with regular support, mentoring and training for their roles. This was through an effective programme of planned supervision and appraisals.

People were provided with information, guidance and support including alternative formats such as easy read or picture cards on how to report any concerns, compliments or suggestions for improvement. The provider was proactive in identifying any concerns before they became a complaint.

Audit and quality assurance procedures were in place and these were proactive and effective. The provider had from records viewed notified the CQC of events that they are required, by law, to do so.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff were knowledgeable and confident about the correct reporting procedures and how to keep people safe from harm.

The provider's recruitment process helped ensure that only suitable staff were offered employment with the service.

People's health, nutritional and care needs were met by a sufficient number of suitably qualified staff.

### Is the service effective?

Good

The service was effective.

Staff knew what assuming people had mental capacity meant.

Staff were supported with training supervision and on-going development

People were supported to eat and drink sufficient quantities of the foods they preferred. People were supported to access health care professionals when required.

### Is the service caring?

Good

The service was caring.

People were cared for by staff who showed consideration and compassion in respecting people's dignity.

Staff encouraged people to make their own choices about things that were important to them and to help them maintain their independence.

People's care needs and the subjects that were important to them were considered and acted upon.

### Is the service responsive?

Good

The service was responsive.

A detailed assessment of people's individual needs was undertaken before they used the service.

People and those acting on their behalf were involved in the assessment and planning of their care.

People's care plans reflected how they liked to receive their care, treatment and support.

Suggestions, comments and concerns were monitored an acted upon before they became a complaint.

## Is the service well-led?

Good

The service was well-led.

People, their parents and family members were actively involved in developing the service.

Proactive and robust audit and quality assurance processes were in place and these were effective.

The registered manager had developed and fostered an open and honest culture which staff felt comfortable with. Staff were supported in their roles.

# Community Support Service

**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 announced inspection took place on 25, 26 and 29 February 2016, was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in caring for people with, a learning disability, with behaviours which could challenge others and those with a sensory impairment.

We gave the provider 48 hours' notice of our inspection because the location provides a supported living service for people who are often out during the day – we needed to be sure that someone would be in.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law. In addition, we contacted the local authority who provided financial support for people to use the service. We did this to obtain their views about how well the service was meeting people's needs.

We spoke with a social worker who helps commission care from the service.

During the inspection we also spoke with three people and 12 people's relatives, the registered manager, two care coordinators and three care staff.

We looked at four people's care records; the minutes of managers' and staff meetings; medicine administration records; and records in relation to the management of the service such as health and safety checks. We also looked at staff recruitment; records related to the supervision and support arrangements in place for staff; the registered manager's staff training plan and complaint and quality assurance records.

Good

# Is the service safe?

## Our findings

People were supported with their care needs, including whilst out in the community, in a safe way and to be as safe as practicable. We found that people were supported with their needs by a sufficient number of staff. This was confirmed by records and what relatives and staff told us. All 12 relatives said they believed their family member was safe when carers supported them, either at home or in the community. This was for reasons such as two to one support, staff being with the person and staff turning up at, and staying for, the agreed amount of time. One person said, "I feel safe because I know the staff so well." One relative said they felt their children were safe because, "It was the fact that staff get to know my children very well." Another parent said, "They [the provider] are very good. They email the hours [the person was to be cared for] and that is very useful." This was to help ensure that people were aware of exactly who was providing their care.

Staff were knowledgeable in recognising any potential signs of abuse and took prompt action if they suspected people were at risk. Records and staff confirmed that they had been trained in recognising signs of harm. One member of staff said, "I have in the past had to report concerns and make sure the child was protected. My manager supported me until we were certain they were safe." For example, by this was by means of accurately monitoring people's skin conditions and those people who were at an increased risk of self -harm. Concerns about people's safety would be recognised and acted upon swiftly. All staff we spoke with were confident in their knowledge of safeguarding and reporting procedures and when this was required. For example, reporting any concerns to the registered manager as well as the local authority and the National Society for Prevention of Cruelty to Children if this was required. This showed us that there were processes in place to reduce the risk of any potential harm.

A social worker told us that generally there were enough staff and that they did not have any concerns about them meeting people's care needs. They also said, "They [name of provider] are clear about being able to support people with the staff that are available. If the staff with the right skills are not available then they do not start the provision of care." This meant that risks to people were minimised. They added that they determined the number of care hours people needed and then sought assurance from the provider that these times could be met. Relatives told is that this was what happened.

The registered manager and care staff confirmed that there were arrangements in place for planned absences such as leave as well as unplanned absences. The care coordinator said, "Yes, we do have occasions where we need to make alternative arrangements. This can sometimes be by another care provider or staff swapping the time care is provided." This was only with the person's or parents agreement.

Risk assessments were in place for any potential accidents and incidents such as where people had experienced a fall or other untoward events. Other risk assessments were in place for subjects including people at risk whilst out in the community, those at risk of choking and those for people with behaviours which challenged others. Other risks included for those people at risk of malnutrition as well as people who were fed through a tube in their stomach. This is called a percutaneous endoscopic gastrostomy (PEG) for people where they are not able to take in sufficient quantities orally. Detailed information about the risks each person presented and what the control measures were available to staff. For example, for people's

behaviours what the triggers were and what calming measures worked best for each known situation. One member of care staff said, "Knowing the people I care for so well makes a massive difference. I can tell by their body language as well as the normal behaviours if they are going to have any [challenging] behaviours." These risks were reviewed regularly to ensure that people were kept as safe as possible. Care staff discussed specific triggers for people's behaviours, such as when going out for a meal. We saw that actions had been taken in response to accidents and incidents to prevent the potential for any recurrences. For example, with the accurate recording and administration of people's prescribed medicines, as well as how to support people to be safe when out in the community. This included all the correct and appropriate procedures to keep people safe such as those following an incident.

Robust recruitment processes and procedures were in place. This was to ensure that only those staff deemed suitable to work with younger people were offered employment. Records confirmed that the checks completed before staff commenced their employment were in place. These checks included evidence of staff's previous employment history, recent photographic identity and enhanced checks for any acceptable criminal records. One care staff described the documents they provided as well as describing their recruitment. They said "[Name of registered manager] interviewed me as well as a senior care staff." The registered manager told us, "We are recruiting more staff. It is an ongoing activity as we can always use more staff. They have to have the right skills and the right attitude to work with children." This showed us that only those staff who met the required standards were offered employment.

People were supported to take their medicines in a safe way. A relative said, "I have never had any issues with when they [care staff] administer [family member's] medicines." Staff confirmed that they had been trained, and been assessed as competent, in the safe administration of medicines. This included clear protocols for staff to follow for people who might need support with their medicine whilst out in the community and medicines which may need administering straight away. Where people's relatives or other care provider administered their medicines, the responsibilities for this were clearly identified and recorded.

Good

# Is the service effective?

## Our findings

We found, that people were supported by care staff who knew people their support needs well. All relatives told us that there were "generally, good relationships" between people and care staff. One relative said "My [Family member's] care staff knows him very well and they get on" and "yes, they have an excellent relationship." Another relative told us, "I am very impressed that they [care staff] spent time at home with [family member] so they could get to know [them] and vice versa, before taking [them] out." This showed us that people were supported by staff who knew them well.

Staff told us about their induction and said that it enabled them to do their jobs effectively with support from more experienced staff and managers. One member of staff said, "My induction [training] covered several subjects including autism, epilepsy, PEG feeding and Makaton [a means of communicating with people who were non-verbal]. All staff spoken with had received training in subjects deemed by the provider as mandatory such as first aid, health and safety, child protection and positive behaviour strategies. This training was accessed through a nationally recognised organisation. Another member of staff told us that it would be easier to name the subjects that they had not been trained in as their training was comprehensive. They went to describe their training, as described above, as well as the use of communication cards and pictures. This was to help support those people who communicated in a different way such as through their body language.

Training records and information we looked at confirmed staff were supported to receive training specific to the roles they were employed in. Other mandatory training for care staff was planned and provided regularly with updates scheduled for staff. This covered subjects such as, but not limited to, managing people's behaviours in a positive way. Staff told us and records also showed that staff were supported to undertake nationally recognised qualifications, which included the Care Certificate. Staff told us about their induction and said that it enabled them to do their job effectively. Staff were, as part of their induction and shadowing, introduced to people gradually. This was so that any person using the service could get to know the care staff coming into their home or taking them out. This was also confirmed in the provider's PIR. One member of care staff said, "My induction was about 12 weeks and then I was on probation for six months. I had a work book to complete and this evidenced my training achievements."

There were mixed comments from family members on the subject of the training given to care staff. One person told us, "Yes, they [staff] are well trained and always abide by the rules." and another confirmed this situation. However, other comments were "There is [sometimes] a lack of [care staff] with sufficient training in my [family member's] complex needs." This means there are [sometimes] gaps in the service [they] receive." The registered manager explained that this was sometimes because of occasional shortages of the right staff. They added that if there was ever a shortage of hours provided then this was generally made up at a later date when staff with the right skills were in place. People we spoke with confirmed this.

Staff described accurately and in a detailed way how people's care and support was provided. One member of care staff described a recent situation where they had identified a change in a person's health condition. They told us that as soon as they saw the person they knew the person was not well. With their, and

parental, support this had subsequently resulted in the person's situation being resolved.

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 including those aged under 18. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. The Act has specific sections which apply to those people under 18 years of age. 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. We checked whether the service was working within the principles of the MCA for those younger people who aspects of this applied to them. No person using the service lacked the mental capacity to make informed decisions either with or without support from their parents or staff.

Staff were aware of how they needed to support some people make certain decisions about their care. For example, due to people's age, ensuring that they were reminded to wear the right clothes and not putting unlawful restrictions in place regarding people's liberty. Care staff we spoke with had not had any training on the MCA. This was confirmed to us by the registered manager. This meant that younger people were at risk of not being supported with the aspects of the Act that affected them. Staff were aware that they always assumed people had capacity and if required they would let people make what may seem unwise decisions. The registered manager had spoken with the local authority about providing a bespoke training package for staff who cared for 16 to 18 year old people. The registered manager was also aware of the circumstances where they would need a Court of Protection order such as for people's financial affairs and how the Act protected staff. Staff were also knowledgeable about the Children's and Families Act 2014 to support people with their rights.

The registered manager told us that to help minimise the risk to people staff who had experience of working with children were generally preferred. However, they also told us that some staff who performed well at interview were then supported with developing their skills. It all depended upon the people they were supporting. One care staff, "I support people who are very young and being with them all the time is very important." Relatives confirmed that this was the case.

Staff confirmed their regular support and formal supervision was a two way conversation and an opportunity to discuss their plans for future training and any additional healthcare related qualifications. One care coordinator said, "I have worked here for over 10 years and in that time I have been promoted so I can help other, including new staff develop their skills. Another member of care staff said, "I don't need to wait for a formal supervision if there is something affecting me or my work. I just pick up the phone or call into the office."

People were involved in decisions about their preferences about what they ate and drank. This included staff's knowledge of people as well as people telling staff by their preferred means of communication. People were supported to eat and drink sufficient quantities. This included treats whilst out in the community as well as appropriate portion sizes and format of food and the way the person took their nutrition through a PEG tube. This was to help ensure that people were safely supported with their nutrition and hydration. Where people had to avoid certain foods or drinks we found that this guidance was adhered to.

Care staff told us, and we found, that they supported people with parental control and support to access health care professionals. This included a physiotherapist, speech and language therapist or a GP when needed. Records we looked at confirmed this. This allowed people and their relatives to contact the relevant health care professional if and when required. We found that staff's knowledge at identifying changes in people's health supported people with their health conditions. This also included maintaining contact with

health care professionals such as paediatricians or school nurses. This was for situations where there was a joint approach to meeting people's health care needs. Other ways people were supported by staff who had been trained on this subject was with non-medicinal interventions to help control epilepsy. This showed us that people's healthcare needs were responded to.

Good

# Is the service caring?

## Our findings

The registered manager explained to us how they considered each person, their care needs and how best to support the person in an individualised way. One person said, "Staff always treat me with dignity and respect. All the staff are as nice as each other." Staff respected people's privacy and spoke with them in a way that was respectful and compassionate. One care staff said, ", "I always care for the person without drawing undue attention to the personal care." Another staff member told us, "Even where people have life limiting health conditions this was not seen as a barrier, but rather as an opportunity to make a difference." People we spoke with confirmed these findings. Relatives' comments were positive about how caring staff were. One relative told us. "They [staff] are very kind and understanding"…."they are very good with [family member]" and "they are fantastic, we are very happy with the service." Another relative said, "They [staff] are superb and have become like family" and "the [staff] are brilliant" …"they [staff] are a god send." None of the relatives we spoke with could recall staff ever speaking about another person in front or with their family members. The registered manager said, "The person's needs come first." We found that where people's first language wasn't English, a range of staff were skilled in supporting people with their preferred language and gaining their confidence. Another person told us, "They [staff] have helped me to be more independent." This showed us that the service considered each person as an individual.

We saw and found that staff were matched, as far as possible, with the people they cared for. Examples included people who had a preference for the gender of their care staff as well as staff who had educational skills. One care coordinator told us, "We have one person who only likes female care staff and this is always respected." Staff responded to people needs. This was with recognition of what the person was communicating. For example, by the person using their communication cards or where appropriate, pictures and when people smiled at something new they had accomplished. This helped people to be understood quickly and easily what staff were saying. One care staff said, "For some younger people, using pictures has made them much more independent, especially where sign language could be too complicated for them [the person]."

Other methods staff used included the person's behaviours or body language. This was to help ensure that staff considered exactly what each person was saying, how they did this and what the impact was. One person told us, "My care worker knows my disabilities so I can be myself." Staff spoke of people's achievements, pointing out what they could do and how this had made a difference to the person's life. Records showed us how people had been supported with their appearance and wellbeing. Relatives confirmed to us that staff were always attentive to people's requests for assistance. One relative said, "They [staff] do encourage my [family member] to be independent by giving [them] choices about where they go." A social worker told us, "It's [the service] very child focused, as expected. Doing tasks such as getting people up for school but doing this in a way which made the person feel relaxed."

People, their relatives and care staff confirmed that people were involved and enabled as much as possible to be involved in their care planning. All relatives confirmed to us that their family members had a care plan in place and they were involved in the planning. One parent told us, "Yes, [family member] has a care plan and we are just re-looking at it." This was also for those people who were not able to tell staff in a verbal

manner what was important to them. Parents said their family member had support to go out to places such as youth clubs, shopping, the gym and theatrical clubs. Parents said this gave their children some added independence, choice and also some respite for themselves. One told us, "They [staff] do encourage my [family member] to be independent by giving [them] choices about where they go."

Care staff described and people we spoke with confirmed various methods they used to help support people with their privacy and dignity. This included enabling people to do the tasks they could do on their own. One member of care staff said of the people she was responsible for, "It helps that we know each other so well as this has encouraged them [the people] to be much more open."
Records we viewed in the provider's office were held securely and only those staff, social workers or healthcare professionals directly involved in people's care had access to these.

The registered manager told us and we saw that information was available to support people or their family members access advocacy. [Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes]. This included organisation such as the National Youth Advisory Service which offers advice, advocacy and legal representation to children, young people or their parents who had legal responsibilities to advocate for their family member. Information about how to contact advocacy services was available in people's care plans and for staff, in the office.

Good

# Is the service responsive?

## Our findings

Staff and relatives confirmed that people's care and support varied from one day per month. If there was a particular concern the registered manager told us they would always try to obtain alternative care for people if their staff were all occupied. This was for situations where people's care was shared between more than one care provider]. One relative told us, "We have no complaints about the management at all" and "we have regular meetings with them." A social worker told us that one of the things the registered manager was good at was providing individualised care. They said, "Some of the children supported have made tangible progress in their communication skills and some have achieved outcomes I didn't think were originally possible. They also said, "Following a period of time with them [the provider] we reassess the situation to make sure the person's needs were being met, especially if a person had behaviours which could challenge others." For example, with two or more staff if the person was out in the community. This not only made sure people had support but it was based on their needs and the outcome they, or their parents, wanted.

The registered manager told us that staff were not just a number. They said, "They [staff] are who they are. We nurture staff based upon their skills. We always try to match staff to people." One care coordinator told us, "If, for example, one care staff is very good at caring for people with a PEG feed and another is good with behaviours which challenge others, this is how we match staff to people." A relative said, "I feel very involved and know how to contact the manager and the organisation at any time if I have any queries or need to talk about anything." One person said about their care plan, "Basically, they [staff] ask me what I'd like to do on the day of my session and that's what I do."

The provider's staff supported people with the hobbies and interests that were meaningful to the person, including playing football, going to a local sailing, or local theatre, club. People were as far as possible encouraged to develop life skills, such as socialising with other people when eating out. The registered manager and care staff explained to us how people that had non-verbal communication skills, were supported with pictures or objects of reference. Staff interpreted their 'yes' or 'no' responses as to whether the person was expressing a wish to take part in a social activity or not. This meant that people were supported in the most practicable way.

The management staff and representatives of the provider had taken time to support care staff to work with people and their parents or foster carers. This also included other significant people in order to obtain and record relevant information about people's life histories. Staff said this had helped them gain an individual understanding of what was really important to each person. This also helped staff identify people's interests and hobbies and how these could be maintained. For example, going swimming and shopping. We also saw and staff told us that they supported people to maintain links with the local community such as going out for a meal. Relatives said the service tried to be flexible with care provided. They said, "We are very happy now but there has been a lack of suitable workers." One person said, "I like to go to see films at the cinema as well as going bowling." Staff confirmed they supported people with these chosen interests.

We saw that people's care plans were very detailed and these included a record of people's achievements.

For example, where a person had completed one of their social interests or hobbies for the first time. These achievements were used to help identify what worked well and where, if required, any changes were required. For example, by recognising any allergies people may have had after they had eaten certain foods, which in future would then be avoided. Records viewed showed us that this had been the case.

The registered manager told us, "We don't get formal complaints as such. We use our monitoring calls to people and their family member's to help gauge their satisfaction." The registered manager was aware, from concerns people or their relatives had raised, that sometimes it was not possible to fill every request for parental assistance. This included respite care or undertaking the amount of time with each person that would be ideal. They told us that if a member of staff was not suitable for any reason this was investigated and if the care could be better met by another member of staff, for example with different care skills, then this happened. The people we spoke with all confirmed that they didn't have any concerns to report. One said, "I get to choose what I want to do and when I want to do it. I have no complaints."

The provider had up-to-date complaints policies and procedures in the form of a service user guide. This included details on how to contact other organisations such as the CQC or the Local Government Ombudsman for social care as well as OFSTED. People were supported with easy read care plans and smiley faces for those areas that were important to the person such as their favourite drink and pastime. Following reviews of people care such as monthly care, or daily sessional reports, changes could be made or more urgently if the need arose. For example, sharing care with another provider or keeping everything in house.

Good

# Is the service well-led?

## Our findings

All staff we spoke with were passionate about making a difference to people's lives. One care coordinator said, "Developing an empathy with people and their families is important. I am passionate about people's equal rights." They went on to describe how they had changed a local swimming facility's perceptions about people's equal rights and how the person was able to maintain their regular swimming session. People told us that there wasn't anything they could think of to improve. One person said, "It's all okay. I like everything about my care."

Strong links were maintained with the local community and included assisting people to attend a swimming lessons, local parks and sensory stimulation at garden centres. The registered manager and staff confirmed that people were encouraged to go to places to improve their social and interactive skills. One care staff said, "It can be challenging sometimes but after a few visits to [name of dining facility] we now have clear boundaries." This showed us that there were measures in place to reduce the risk of people's social isolation.

The service had a registered manager. They had from records viewed notified the CQC of events that, by law, they are required to do so. The registered manager told us and we saw that staff's achievements had been recognised. For example, by being informed of what they did well during supervisions and the differences they had made to people's lives. One member of staff said, "She [registered manager] is definitely a good manager. If I raise any issues she will address the matter within 24 hours if possible." They also said, "They [the registered manager] are very approachable." Another staff member said, "[registered manager] is absolutely there for me. Whenever I need help I don't ever have to worry about telling them anything." A social worker told us, "It [the service] is all managed really well; from the initial positive foundations to the point where I rely on their [the provider's] support."

Care staff told us about the values of the service and how these were embedded in everything they did. These included treating people as an individual, with equality and putting people first in everything. Examples given included supporting people with their birthday party or during difficult times of people's lives such as when they were not well. People gave us examples of how well-led the service. One person said, "It doesn't matter which staff care for me they are all nice. Another person said, "All staff are skilled at doing the right things for me." One relative said, "The staff give me a break so I can catch up on other things but my [family member] gets all the benefits."

The registered manager, social worker and relatives told us how people and staff were actively involved in developing the service. This included regular face to face discussions with people, their parents or foster carers, staff and with various meetings with health care professionals. This was to help ensure that people experienced the best outcome. Other ways quality assurance monitoring was undertaken was by management staff completing spot checks of staff's medicines administration practice and standards of care provision. This helped the provider determine whether any person needed additional or less support and that staff were working to the standards expected of them.

The provider had an audit process in place to monitor the effectiveness of any actions taken for identified concerns. This included analysing information from previous incidents such as errors associated with medicines administration. For example, following one incident the registered manager had reviewed policies, procedures and audited records. This was to make sure that the situation could not occur again and limited the chances of this occurring with anyone else.
The provider gained people's views with a satisfaction log. Recent comments we saw included how grateful parents were for the "team's help" and "appreciate it very much" and "feedback to the social worker about how [staff's] input has made a huge difference to family life and [they are] now able to sleep."

Staff were supported with supervisions, appraisals and on the job mentoring. Regular staff meetings gave staff the opportunity to comment on any areas they felt would benefit people. For example, one care coordinator told us, "We are very much a team." They also said, "We have management meetings with an agenda as well as time to reflect on decisions such as the review of the body map form and also the new 'All about me' forms for better information of people's preferences."

The registered manager attended forums arranged by the provider to share good practice and also if other services had experienced similar situations. This included information from the local Children Safeguarding Board, as well as considering the way the CQC inspects services and how the provider gained positive aspects from our reports as well as opportunities for improvement.
The registered manager told us and we saw that they kept staff up to date with information from national organisations; this included those for people with a learning disability and also for people with various health conditions. This helped ensure that staff were working to the latest standards of care provision as well as this being to the benefit of the person. A social worker told us, "[Registered manager] attends our meetings and feeds in to these with helpful suggestions on how people's care needs were met where care was shared between more than one provider."

Staff told us that they were aware of whistle-blowing procedures and would have no hesitation in reporting their concerns. This was if ever they identified or suspected poor care standards. They said, "If I saw poor care I would have no hesitation calling [registered manager]. I feel confident that they would support me."