United Response

United Response - Supported Living: Exeter and East Devon

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 11 and 12 July 2018 and was announced. This was first inspection since a new provider, United Response, registered the service on 27 June 2017.

United Response Supported Living Exeter and East Devon (formerly known as Robert Owen Communities) provides personal care to 12 people in supported living in Exeter, Exmouth and Honiton areas. Support ranged from a few hours a week to 24 hours a day. This was so people could live in their own home as independently as possible. United Response is a UK wide registered charity that supports adults and young people with learning disabilities, including autism, sensory impairment, and people living with dementia, mental health needs and physical disabilities.

People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. People using the service lived in houses with their own bedroom and shared toilet, bathroom, kitchen and lounge facilities. Everyone paid rent to a landlord and contributed towards shared utility bills and other expenses.

Not everyone using United Response Supported Living Exeter and East Devon receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the time of the inspection, the service did not have a registered manager. The previous registered manager had moved to a new post and deregistered. Another manager who worked in the service had taken on the role and was in process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were at the heart of the service, which was organised to suit their individual needs and aspirations. People were supported by exceptionally committed staff that were compassionate and treated them with the utmost dignity and respect.

Care and support was person centred and well planned. People were part of their local community and led interesting and fulfilling lives. Staff supported them to live as independently as possible and do their own cooking, shopping, laundry and housework, according to their ability. People had a wide range of hobbies

and interests, and were part of their local community.

Prior to the inspection we received several safeguarding alerts from the service about a person whose behaviours others found challenging. Although none of the people involved received a regulated activity, the service kept us up to date about how they were working with those people and with other agencies to protect them and meet their individual needs.

People felt safe and well cared for by sufficient staff who received good training and support to do their job safely and effectively. The risk of abuse was minimised because staff demonstrated a good understanding of what constituted abuse and knew how to report concerns within the service and to external agencies.

Risk assessments were in place for each person to minimise risks as much as possible in the least restrictive way. People received their medicines safely and on time. Accidents and incidents were carefully monitored, analysed and lessons learnt from mistakes.

Safe recruitment practices were followed before new staff were employed to work with people. People had a range of ways through which they could raise concerns. People's concerns and complaints were listened and responded to.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and understood how this applied to their practice.

The service was well led by the manager and area manager, who led by example. Robust quality monitoring systems were used to monitor and continually improve. People, relatives and staff were regularly consulted and involved in developing the service. Staff used evidence of what works best to continually review and improve their practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and trusted staff. Staff knew how to recognise signs of abuse and how to report suspected abuse.

People's risks were managed to reduce them as much as possible.

Staffing arrangements were flexible to meet people's individual needs.

There were effective recruitment and selection processes in place.

People received their medicines safely and on time.

People were protected from cross infection through good hygiene practices.

Is the service effective?

Good

The service was effective.

Staff received training and supervision which gave them the skills and confidence to meet people's needs.

People's health needs were managed well, staff recognised and reported changes in their health and followed the advice of health professionals.

People's rights were protected because the service acted in accordance with the Mental Capacity Act (2005).

People were supported to maintain a balanced diet.

Is the service caring?

Outstanding

The service was exceptionally caring.

The ethos was one of an extended family. Staff 'went that extra mile' to meet their needs and wishes of people they supported.

Staff were inclusive and developed exceptionally positive, kind, and compassionate relationships with people.

People's privacy, dignity and independence was respected.

People's rights and choices were promoted. They could express their views and were actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive.

People were supported by staff they knew well and had developed trusting relationships with.

People's care was personalised to their individual needs.

People were supported to make friends, learn new skills and be involved in their local community.

People knew how to raise concerns and complaints which were positively responded to. Information about complaints was provided in a format suited to their needs.

Is the service well-led?

Good

The service was well led.

The provider promoted a positive culture that valued people and staff.

Staff worked well together as a team and felt well supported by local managers.

People's views and suggestions were sought and considered to improve the service.

The provider monitored the quality of care provided and made continuous improvements in response to their findings.

United Response - Supported Living: Exeter and East Devon

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.

The inspection took place on 11 and 12 July 2018 and was announced. An adult social care inspector completed the inspection. We gave the provider 48 hours' notice of the inspection visit to ensure the manager was available. Also, so they could invite people using the service to participate in the inspection.

The provider completed a Provider Information Return, (PIR) which we used to help prepare for the inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, such as contact from the service, members of the public and through notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

In preparation for the inspection, we sent 17 questionnaires to people identified as able to able to respond to questionnaires and received six responses. We also sent 17 questionnaires to friends and relatives but received no responses. We sent 25 questionnaires to community health and social care professionals and received three responses. We sent 53 questionnaires to staff and received no responses. (The service thought this was because staff e mail addresses provided had changed during the organisational change).

During the inspection we visited two supported living services and met with 10 people to seek their views about the service. We spent time in communal areas with them and observed their interactions with staff, which helped us make a judgment about the values of the service.

We looked in detail at three people's care records and at their medicine records. We met with the manager, another local manager, the area manager and with three care staff. We spoke by telephone with a team leader and another member of care staff. We looked at seven staff files which included details of recruitment, training, supervision and appraisals. We looked at staff meeting minutes, accident and incident reports, and at records of observations of staff providing care in people's homes. We also looked at the providers quality monitoring systems which included audits of medicines, care records and staff training.

We sought feedback from commissioners, Healthwatch England (the consumer champion for health and social care), as well as from health and social care professionals. We received a response from six of them.

Good

Is the service safe?

Our findings

People said they felt safe and were relaxed and chatty in the company of staff. One person said, "There are nice people here" and another said, "The staff are very good and I feel safe here." All six people who responded to our questionnaire confirmed they felt safe with staff who were skilled and reliable.

People were protected and the risk of abuse and avoidable harm was reduced because staff received safeguarding adults training, and knew how to recognise signs of abuse. There were systems in place for staff to report concerns about abuse and staff knew how to raise concerns and had no hesitation in doing so. The provider had a safeguarding policy which included contact details of for external agencies and more senior staff.

For example, recently staff noticed that a person who previously managed their finances independently was putting themselves at risk when they were out shopping. An individual risk assessment identified areas they now needed support with, such as using their bank card and accounting for expenditure. Staff worked with the person, who was fiercely independent to identify ways acceptable to them in which staff could support them to minimise their risk of financial abuse.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. This included undertaking a Disclosure and Barring Service (DBS) criminal record check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

A detailed risk assessment of each person was undertaken and care records included steps staff needed to take in order to reduce individual risks as much as possible. These were updated as people's needs changed. For example, where people exhibited behaviours that challenged others, care plans highlighted triggers that might upset the person, and highlighted positive ways to engage and distract them. Staff recorded details of those changes on behaviour charts which captured the strategies staff used to distract and reassure them. This helped keep health professionals informed about any behaviour changes.

A positive approach towards risk taking was adopted by the service to give people opportunity to be as independent as possible. For example, when a person had taken their own tablets for many years had the dosage increased, they struggled with managing a second tablet. So, staff administered the second tablet, which meant the person continued to maintain some responsibility for taking their own medicine.

Several people accessed their local community independently. The service had compiled missing person information on each person so emergency services had relevant information, should anyone get lost or fail to arrive at the expected time. Emergencies were planned for, for example, each person an personal emergency evacuation plan about the support they would need to evacuate their home, in the event of a fire.

People's individual support needs were determined by local authority reviews carried out in 2017. Each person had a set number of one to one staff support hours each week, which they could use flexibly. This meant people could decide when they wanted their one to one staff support. For example, for doing household chores, shopping and going out. Outside of those hours, people had shared hours during the day and a sleep-in member of staff overnight who was available for emergencies.

Where people's needs changed, staff liaised with the local authority to increase their staff support hours, to maintain their safety and wellbeing. For example, when a person's health and mobility deteriorated and they needed more support.

People in each supported living service were supported by a regular team of care staff they knew and trusted. Where there were any staff shortages, such as short-term sickness, these were covered by staff working extra hours, which ensured people received good continuity of care.

People received their medicines safely and on time. Detailed assessments made clear what level of staff support people needed with their medicines. For example, making sure a person was visually and verbally prompted to take their medicine.

All staff were trained in medicines management and had competency assessments to check their skills and knowledge before they could administer people's medicines. For a person with specialist medicine needs, who received their medicine by continuous pump, staff were trained to manage this safely.

Accidents and incidents were reported and monitored to look for trends and identify any further changes to prevent recurrent risks. Incident reports highlighted several medicine recording errors in one household whereby staff were frequently forgetting to sign medicine administration records (MAR) sheets. Previously people were administered medicines in communal areas, where there were distractions, so lockable cabinets were purchased for each persons' room. This meant people's medicines were administered in their room, without distractions, and staff signed the MAR sheet immediately to confirm administration. These measures significantly reduced medicine recording errors.

People were protected from cross infection. Staff had completed infection control training and wore protective gloves and aprons when providing personal care.

Good

Is the service effective?

Our findings

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. For example, what time they wanted to get up, what they wanted to wear, eat and how they wished to spend their day. Care plans included details about ways in which people could be supported to make as many decisions for themselves as possible. For example, a person's care plan showed they found it difficult to cope with too many choices. So, staff were advised to restrict choices to two to three options to help them make decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care records included next of kin so staff knew who the person wanted them to keep in contact with. Where people lacked capacity, relatives and other legal representatives were consulted and involved in making best interest decisions about the person's care, along with other health and social care professionals, as appropriate. For example, in relation to deciding a person needed support to manage their finances.

People received effective care and treatment from staff who had the relevant qualifications training and competencies needed to meet their needs. All six people who responded to our questionnaire and people we met confirmed staff had the skills to meet their needs.

Most staff who worked in the service had qualifications in care, and five staff were currently working towards a higher level qualification. Training included e-learning and face to face training. For example, first aid, fire safety, moving and handling, food hygiene, safeguarding vulnerable adults, and the Mental Capacity Act (MCA). Staff received additional training relevant to people's individual care needs. For example, dementia, autism awareness and epilepsy training including the use of emergency medicine. The local mental health team also provided bespoke training to a staff team working with a person with a long term mental health condition. This helped them recognise signs of deteriorating mental health and taught them strategies to help the person manage their anxiety. Other staff were trained in British Sign Language (BSL), so they could communicate effectively with deaf people they supported.

A newer member of staff praised the support they received from other staff when they first started working for the service. They said, "I love all of it. It's the first job I feel really confident in, I look forward to going to work, other staff are so supportive." New staff worked alongside experienced staff to learn about how to provide care to meet each person's individual needs. Induction was flexible according to needs and previous experience of the new member of staff. Staff new to care were supported to complete the 'Care Certificate.' The Care Certificate is a set of standards that social care and health workers are expected to adhere to in their daily working life.

The service had recently started to use observational supervision records to capture how staff interacted

and engaged with people they supported. Senior staff regularly visited and observed staff interacting with and supporting people in their own home. This allowed them to monitor standards of care and communication and ensure staff had the relevant experience, skills and attitudes to support people. These observational visits were a positive way to give constructive feedback to individual staff, and identify additional training needs. Any actions agreed at individual meetings were followed up at next meeting to ensure they had been completed.

People's healthcare needs were met by staff who made sure people attended regular health appointments, such as chiropody, dental and GP appointments. Staff knew people well and worked closely with health professionals to make sure people's changing health needs were met. Each person had a health action plan about their medical and health needs, so staff have the information needed to help them remain healthy and active. For example, a personalised regular exercise programme and details of any specialist equipment and moving and handling needs. A 'hospital passport' provided key information about each person, their communication and health needs, in the event they needed a stay in hospital. These enabled staff to identify and respond appropriately to each person's well-being.

People were supported to improve their health through good nutrition. Staff encouraged people to eat a well-balanced diet and make healthy eating choices. For example, by encouraging people to include fruit and vegetables in their menu planning and shopping list. Where people needed to lose weight, staff reminded people of benefits of maintaining a healthy weight for their health and mobility. People showed us examples of healthier food choices such as low sugar squash, jelly and low-fat yogurts. Where a person liked chocolate, but needed to lose weight, they agreed to a weekly chocolate treat so they could continue to have their favourite food in moderation. In both services, we visited, people sharing the house chose to have their main meal together in the evening. They planned those meals in advance weekly, so they could shop for their ingredients. Several people enjoyed cooking and preparing meals with staff support.

Outstanding ☆

Is the service caring?

Our findings

People received support from staff who provided exceptionally person centred, kind and compassionate care. People's comments included, "Staff are kind," "Staff are all friendly" and "I have lots of friends." A staff member described the supported living service they worked in as a "happy home", one where there was a family atmosphere. Another staff member said, "I love it here, the people who live here are all so different, they all seem happy." People lived their own lives and helped one another out. A professional praised how everyone the service supported was included and encouraged to have a voice.

People were treated with utmost kindness and respect by staff, who knew people well and how they liked to be supported. Staff were respectful in the way they spoke with people and listened to their views. When a person spoke openly with us about the recent loss of a family member, staff sensitively supported them and reminded them of fond memories of their loved one. Observational supervision records captured how a staff member noticed when another person looked tired and asked if they were OK.

The service was committed to valuing people, and treating people as they would wish to be treated themselves. They used a person-centred approach, which put people at the centre of the service. As a member of the Voluntary Organisations' Disability Group they respected and promoted the rights of every person they supported by campaigning around issues that were important to and for people with learning disabilities.

For example, in the provider information return, the service highlighted an initiative to get people to complete "treat me well forms." These highlighted the support individuals need to access NHS care and to make informed choices. For example, that the GP surgery needed to book a British Sign language (BSL) interpreter for a deaf person's health appointments. Also, that surgery staff needed to use simple language and short sentences and provide people with health information in an 'easy read' format. The area manager said local surgeries had responded positively to this initiative, which they said helped them ensure people gained optimum benefit from their appointments.

A local authority professional praised the way United Response advocated for people during a local authority review of people in supported living services across Devon in 2017. The review was to check individuals were getting the support they needed. Also, to clarify any shared support arrangements to make sure they were transparent and fair for everybody, represented a quality service and was value for money.

The professional described the service response as "absolutely fantastic." They said local staff and managers ensured people, families and advocates, where appropriate, were supported to participate in the review. Because staff knew people so well, they represented people's individual support needs well to the review team. This meant the service review was concluded in a way that favoured people and maximised the impact on their funded care and support.

Staff went that extra mile for people they supported. When a person developed a serious illness, their key worker helped them through their initial day surgery and subsequent treatment. They and a family member

accompanied the person to each treatment appointment. They took photographs of them having their treatment and used them to explain, remind and prepare the person in advance for the next treatment. This meant the person completed their treatment course without distress or the need to be admitted to hospital, supported throughout by staff they knew and trusted.

People's rights to a family life were upheld by staff who supported people to keep in contact with their family and friends. For example, through face to face contact, email, telephone and via social media. People visited family regularly and staff helped them welcome visitors to their home . One person was excited about a trip home on the train at the weekend to visit family and showed us pictures of their nieces and nephews and family weddings. Another person told us about a recent significant birthday and how staff helped them organise a celebratory birthday party for friends and family recently at a local venue.

People were supported to express their views and staff involved them in decision making about their care, according to their ability. Each person was asked about what was important to them and this was captured in their care plan (known as a working policy). For example, that a person was fiercely independent and didn't appreciate being prompted by staff in public places. People had regular meetings with their key worker to review and update their care plans and to make future plans, for example activities, trips and holidays.

Staff understood people well, for example, a person with limited verbal communication skills. The person had their own names for staff, which were well understood. For example, the person referred to a staff member as "girl" and often said "No" when they meant "Yes", which staff were aware of, so knew to recheck.

Staff supported people with their appearance. One proudly showed us their jewellery collection and staff told us how another person pointed at pictures to show staff how they wanted them to style their hair. When we admired a person's dress, they told us staff helped them to choose it from a catalogue and ordered it for them.

United response promoted that all individuals had the right to be treated with dignity and treat others with respect. They achieved this in day to day practice, through supervision, staff induction and in working with other agencies and community groups. Community professionals who responded to our questionnaire confirmed staff treated people with dignity and respect. Where people expressed a preference for female care workers only, their choice was respected. In services where people were deaf, staff turned a light on and off to attract people's attention, and awaited the person's response before going into their room.

Care plans included ways in which staff could promote people's dignity. For example, that a person needed prompting to be appropriately clothed when mixing with other household members in communal areas. To promote people's independence with personal care staff prompted a person to wash intimate body areas when showering.

People's equality and diversity was recognised and respected by staff who completed equality and diversity training. Cultural differences were celebrated and upheld. Two people attended local church services each week. Staff supported a person to celebrate Chinese New Year in London and arranged for a person to wear red clothing on the day of their relative's funeral, in accordance with their cultural traditions.

Staff supported a person to understand their sexuality and communicate with family and friends about this. They helped another person to pursue their wish to have a relationship, which had a positive impact on their confidence and emotional wellbeing. Staff reminded and re-enforced acceptable boundaries and behaviours towards others and on social media with them.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their individual needs. People's comments included, "Staff are very good," "I like to be independent," and "you can do your own stuff." A staff member said, "Everyone has their own life, people can do whatever they want to do, stay in or go out in the community, there is never a dull moment."

One person liked to go out in the evening and wanted to use some of their staff support hours to stay up late. Staff worked flexibly to accommodate this person's preferences and their preferred staff. A person who needed regular blood tests to manage a chronic health condition had become scared of needles. So, support staff worked with the person and their local GP practice to help them overcome their fear. This was done in steps, for example, through regular visits to the GP practice and the use of local anaesthetic 'magic cream.' Over time, these steps were successful. Having regular blood tests has meant their medication can be adjusted regularly to maintain their wellbeing.

Before people received a service, an assessment of their needs was carried out and a care plan was drawn up and agreed with them. Care plans and risk assessments were detailed and personalised about their individual needs. A professional said, "Care plans are excellent." People's care plans included details of their likes and dislikes, their hobbies and interests. For example, that one person liked knitting, sewing, going out for coffee and cake and liked to ask lots of questions. Another person loved animals and was hoping to get a dog and pursue a career that involved working with them. Daily logs were kept for each person which recorded relevant information about the support they needed for personal care, details of meals, activities undertaken and about their mood and emotional wellbeing.

People led busy and fulfilling lives, they were actively involved in their local community and were well known in local shops, cafes and pubs. The service recognised the risks of social isolation and loneliness and made sure each person had a network of support from people they lived with, family and friends, staff, neighbours and others who attended their community groups.

United Response offered a range of social and recreational activities for people they supported. For example, Robert Owen Community (ROC) Active in Exeter which enabled people to have healthier lives through keeping fit and participating in sport. Also, ROC Wellbeing, Honiton, which provided developmental activities and arts projects. The provider also had a virtual college, ROC Life College, which developed bespoke learning and development courses. For example, to help a person gain skills and qualifications to work in the catering industry. The service also worked with other charities and voluntary organisations. A person told us they enjoyed playing Bingo at a weekly club for older people, another person liked their weekly men's only group. Others attended an evening activity club, a Magic Carpet group which offered arts, crafts, drama, music, as well as local church and community coffee mornings and lunch clubs.

People living in shared accommodation all contributed to day to day household tasks. For example, cooking, cleaning and doing their laundry and grocery shopping. One person said, "I like helping in the kitchen and with hoovering." Several people did voluntary work, which included working in a charity shop, a

local pub, gardening and growing vegetables.

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Personalised care plans demonstrated how the service met people's individual communication needs. They included details of any hearing or visual impairments and ways used to help people with effective communication such as British Sign Language (BSL). BSL is the language of the deaf community in the UK. The service also used picture exchange communication system (PECS), symbols, objects of reference and Makaton where appropriate. An object of reference is any object used to represent an item, activity, place, or person, for people who find it difficult to understand spoken words, signs, symbols or photographs. Makaton uses signs and symbols, with speech, in spoken word order to help hearing people with learning or communication difficulties. For example, a picture and symbol daily planner reminded a person of what order they liked to do things each day. A deaf person's care plan showed they used BSL but had basic skills which could cause misunderstandings. So, staff were instructed to use other methods as well to check the person understood.

Further improvements were needed to ensure people were given the opportunity to plan ahead for their end of life care. Staff in one supported living service had recently identified the need for training in this sensitive area. This was to help prepare them to talk to people sensitively about death and dying and capture any advance decisions or wishes they expressed about end of life care. In response, the service was adding an end of life care training module to their e-learning. They were also arranging for a hospice nurse to share tips on discussing advanced decision making, and the role of the hospice in providing end of life care.

Prompted by the inspection, staff were made aware of an end of life care plan proforma entitled "What I want and what I don't want in the future" they could use. Guidance was circulated to staff about how to capture and record people's views about resuscitation, the withdrawal of treatment and preferred funeral arrangements. When implemented, these measures will ensure people have end of life care plans, which let other family members, friends and professionals know what is important for them in the future.

The service had a written complaints policy and procedure that provided information for people about how to raise a complaint in an easy read format. This included details of senior managers within United Response and other organisations people could contact if they were dissatisfied with how their complaint was being dealt with by the service.

People who responded to our questionnaire confirmed they knew how to complain and said staff acted in response to any concerns raised. They were asked if they had any concerns at individual review and at regular tenant meetings and service visits by managers and team leaders. This meant they had a variety of ways to raise any concerns. Staff were proactive in addressing any day to day tensions before they became bigger issues.

One formal complaint had been received by the service in the past twelve months, which did not relate to people receiving the regulated service. The complaint log showed it was investigated, and the response demonstrated the service apologised for things that went wrong and learnt from their mistakes. For example, in covering the rota in response to staff sickness. This showed complaints were used as opportunities to make further improvements.

Good

Is the service well-led?

Our findings

The service was well led. People and professionals gave us positive feedback about the quality of people's care. Local managers and leaders had supported people and staff well through the transition to a new provider. Locally, staff said people didn't notice any changes and staff had good continuity of managers. The service was still in the process of moving existing paperwork over to United Response templates and harmonising quality monitoring systems.

The United Response mission statement was to make sure people with learning disabilities, and with mental health or physical support needs had the opportunity to live their lives to the full. The service was committed to improving the lives of people they supported, where everyone had equal access to the same rights and opportunities. The provider set clear expectations of roles and responsibilities of staff and the standards expected in a staff code of conduct.

United Response promoted wellbeing of staff as an important part of providing high standards of care to people they supported. In addition to local support from team leaders and managers, staff had access to a counselling support service and occupational health services.

At the time of the inspection, the service did not have a registered manager. The previous registered manager had been promoted to area manager and deregistered. Another manager who already worked in the service had taken on the role and was in process of registering with the Care Quality Commission. They were being mentored and supported by the area manager to take on the role, which meant there was continuity of leadership. 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 manager was in day to day charge of all supported living services in Exeter and East Devon. They were supported by geographically based team leaders, who managed care staff teams in each supported living service. Two team leader posts were currently vacant, so the manager was currently helping with staff rotas and some sleep-in duties. The manager led by example and encouraged staff to make decisions by using a coaching style of leadership. They shared knowledge and encouraged learning in practice. For example, using experienced team members to act as role models to less experienced staff.

The manager and area manager said there were lots of benefits in being part of a national organisation. For example, access to policies and procedures, training, access to specialist advice and support with managing people's individual needs and with managing staff. Staff reported positively about working in the service and the support they received. One said, "People are happy, busy and have opportunities to be part of communities. Another staff said, "I absolutely love it, loads of training. I think it runs really well, managers are supportive, there is always someone at end of phone for advice."

The service had whistleblowing policies in place. Where any concerns about staff skills, performance

attitudes or performance were identified, these were dealt with through supervision and training. Where necessary more serious issues were dealt with in accordance with the provider's disciplinary policies and procedures.

In each supported living setting a staff information file was used to update staff and communicate changes and updates in relation to people's health, family, or professional input. Daily planners captured each person's plans for the day and recorded daily tasks completed by staff. For example, finance checks, medicine administration records and any appointments made for people.

The service used a range of quality monitoring systems such as audits of care records, medicines management, accidents/incidents and complaints. A continuous service improvement plan identified any improvement actions identified. This demonstrated the service followed up and monitored improvements were completed and working effectively.

The manager completed monthly managers' reports which provided local data about accidents, incidents, complaints, and staffing information to the provider. Local managers undertook six monthly audits for services they were not responsible for, which is good practice. This provides a fresh perspective to highlight good practice and areas for improvement. The area manager carried out quarterly audits and checked on progress of any improvement actions identified at the previous audit. For example, in relation to improvements in medicines management through staff training and competency assessments. Other occasional audits from head office were also carried out. For example, a random audit of two people's finances to ensure staff were following the providers polices and procedures.

Regular staff meetings were held, staff were encouraged to contribute to agenda items and participate in discussions. An employee survey was undertaken a few months after United Response took over with low response rates. This was followed by up by face to face meetings so staff had a further opportunity to feedback. One area staff highlighted for improvement was staff access to computers to access e learning and United Response policies and procedures. So, a laptop for staff use was made available in each supported living service. Staff briefings were sent via email to all staff monthly, which provided internal and external changes and developments with the sector.

People had an opportunity to give feedback about what was working or not working through regular tenants' meetings. These provided an opportunity to air views and tackle day to day issues people sharing a house experienced. For example, about ways to ensure people respected others watching TV in lounge by not speaking loudly on the phone.

In the provider information return, the service outlined ways in which they kept up to date with developments in practice. This included by following the National Institute for Health and Care Excellence (NICE) guidance. Also by using the Social Care Institute for Excellence (SCIE) and Care Services Improvement Partnership (CSIP) good practice tools to identify and implement good practice. Local managers were members of the Proud to Care Devon group which promotes best practice in managing and training staff working in health and social care. Local care staff were members of Devon Link Up, an independent charity for people who have learning disabilities and / or autism. Within United Response staff and management had opportunities to keep up to date with developments and share good practice through team meetings and regional meetings. A United Response newsletter shared good practice stories and celebrated people's achievements.

The service worked in partnerships with a number of agencies such social services, GP and with the local Intensive Assessment and Treatment Teams (IATTs). These provide support for adults with learning

disabilities experiencing or causing in others high levels of distress. The team included psychiatrists, psychologists, occupational therapists, speech and language therapy, physiotherapy, and registered nurses.

The manager had notified the Care Quality Commission (CQC) about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. Out of hours, an on-call manager system provided staff with access to advice and guidance when needed.

In the provider information return the service outlined plans to further personalise complaints information by creating bespoke complaints information for each person. They had plans to pilot a project to use digital technology to help people create their own care plans. Also, to use multimedia videos to demonstrate to staff ways to meet people's individual care needs, for example, by making videos of physiotherapy sessions, teeth cleaning support and independent living task videos. These showed the provider was committed to further improvements.