Royal Mencap Society

Royal Mencap Society - 1-2 Broadstone Close

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which took place on 16 and 17 January 2017. We had previously inspected this service on 17 and 19 November 2015 when we found that the service had not met all the standards inspected and was rated as Requires Improvement.

1-2 Broadstone Close is two semi-detached houses which are joined together with an internal adjoining corridor. Although 1-2 Broadstone Close is registered as one service with the Care Quality Commission, people living there consider them as two separate houses and treat them as such. Four people live at 1 Broadstone Close, and five people live at 2 Broadstone Close. The service is registered to accommodate nine people for nursing or personal care. The service does not provide nursing care. Nine people were living there at the time of our inspection. The service provides support to people who have learning disabilities.

The service had a registered manager in post at the time of our inspection. 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.

There was not always enough staff to support people at times when they needed. People, relatives and health and social care professionals felt there were occasions where additional support should be available to ensure people's needs were met.

People had mixed views about the amount of support they had to take part in activities in the home and the local community. Staff were not consistently recording what support was offered, and what actually happened. The provider could not assure themselves people were being encouraged and supported to take part in a range of activities and hobbies that were meaningful to them.

People were protected from the risk of abuse, and staff were knowledgeable about how to recognise and report concerns of abuse. There were systems in place to protect people from the risk of harm and abuse, and people, relatives and staff felt confident to raise concerns about unsafe care. People were supported to be as independent as possible whilst remaining safe. Key information about people's care needs was available to staff in the event of an emergency.

Staff were recruited in a safe way. The provider took steps to ensure checks were undertaken to ensure that potential staff were suitable to work with people needing care. Staff received regular supervision and had checks on their knowledge and skills. They also received an induction and training in a range of skills the provider felt necessary to meet the needs of people at the service. Staff received training and ongoing supervision to ensure that their skills, attitudes and values met the provider's requirements.

Medicines were managed, stored, administered and disposed of safely. Staff received training and ongoing skills assessments that enabled them to be confident in supporting people with medicines.

People consented to care and support in many aspects of their daily lives, and were encouraged to make their own choices. Appropriate arrangements were in place to assess whether people were able to consent to their care, where this was needed. The provider met the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). This ensured people's care was provided lawfully, and they had their rights respected.

People were supported to have a varied and balanced diet. People were encouraged to participate in the planning and cooking of meals. They had access to a range of health and social care professionals for advice, treatment and support. Staff monitored people's health and well-being effectively, and responded quickly to any concerns.

People felt cared for by staff who treated them with kindness, dignity and respect. People, their relatives, and staff felt able to raise concerns or suggestions in relation to the quality of care, and were confident the provider would take action where needed. The provider had a complaints procedure to ensure issues with quality of care were addressed. People were involved as much as possible in planning and reviewing their own care, and had access to independent advocacy to support them to do this.

There were systems in place to monitor the quality of the service. There were checks in place to ensure the service was of good quality, and the provider could demonstrate where improvements had been identified and made. However, the quality monitoring had not identified issues with staffing levels, and the potential impact on people's quality of life. The registered manager understood their responsibilities, and CQC was appropriately notified of events as required.

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 not consistently safe.

There was not always enough staff to support people. People were protected from the risk of abuse, and staff knew how to identify potential abuse and raise concerns. The provider carried out checks to ensure people were cared for by staff who were suitable.

Is the service effective?

Good

The service was effective.

People received effective care from staff who had the knowledge and skills to meet their needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 to ensure that people's care was provided in the least restrictive way. People were supported to maintain their health care.

Is the service caring?

Good

The service was caring.

People were supported by staff who treated them with kindness and respect. People were involved in making decisions about their own lives as much as possible. Staff spent time establishing what people's wishes and preferences were, and providing support which was personalised.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not consistently supported to take part in a range of activities and hobbies that were meaningful to them. People knew how to make complaints, and the provider had a clear process in place to hear people's views and act on them.

Is the service well-led?

Good

The service was well led.

People, relatives and staff were able to contribute towards the

development and improvement of the service. The provider had systems in place to assess the quality of care people received, and to make changes where necessary. The provider made notifications to CQC in accordance with the regulations and staff understood their roles and responsibilities.

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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 was an unannounced inspection which took place on 16 and 17 January 2017. The inspection was carried out by one inspector. Before the inspection, we asked the provider to complete 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. This was returned to us by the service.

Prior to the inspection, we reviewed all the information we held about the service, including statutory notifications that the provider is required to make to CQC and information from local authority commissioners. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with six people who lived at the service, one relative and six staff, including the deputy manager, registered manager, and area manager for the provider. We looked at a range of records about people's care, including three people's care files. We reviewed records of the checks the registered manager and provider made to assure people that they received a quality service. We looked at records for two members of staff to check that suitable recruitment procedures were in place, and that staff received training and support to enable them to provide care that met people's needs.

Good

Is the service safe?

Our findings

People did not always have staff available to support them when needed. People had mixed views about whether there was enough staff available to support them to go out, or to help them with daily activities at the times they needed. One relative commented that, at times, they felt there were not enough staff. Health and social care professionals we spoke with felt staff were not consistently proactive in supporting people to take part in activities, both in terms of daily personal care and meaningful activities in and out of the house. We saw that, whilst two people were able to go out without staff support, the seven other people at the service needed varying levels of staff support in and out of the house. Although the service is registered as one house with the Care Quality Commission, people thought of the service as two separate houses and treated them as such. Four people lived at 1 Broadstone Close, and five people lived in number two.

Staff felt there were times when there were not enough of them to support people. One staff member said, "If I take one person to a hospital appointment for three hours, this leaves one staff member and the [registered] manager." Another staff member commented, "Sometimes there is one staff covering the two houses. That's a problem with people's needs and a big responsibility for me." Staff also expressed concern about night time staff levels, saying there was one staff member to support nine people. Staff told us, and rotas confirmed, there were two staff during the day (and also the registered manager) with an additional third staff member scheduled in if people had planned appointments or activities. One person also had additional one-to-one support for several hours every day. Evidence also confirmed that either the registered manager or deputy manager were available during the day to support staff when required. Staff said and records confirmed there was one staff member on shift overnight. We identified that two people needed support to mobilise at night, and a third person would also need support due to their health condition. The provider had an on-call system to enable staff to request support if needed, but staff support would not immediately be available in an emergency at night if needed.

People were protected against the risk of abuse. People and their relatives told us they felt safe and protected from the risk of harm. One person said, "I like it – it's safe here." A relative commented, "[Family member] is safe there – if I was concerned I'd be straight on the phone. I am very confident in the staff." Staff knew how to identify people at risk of abuse and were confident and able to report concerns about abuse or suspected abuse. They also knew how to contact the local authority or the Care Quality Commission with concerns if this was needed. The provider had clear policies on safeguarding people from the risk of abuse, and staff knew how to follow this. Staff received training in safeguarding people from the risk of avoidable harm and this was supported by their training records. Records at the service and information held by CQC confirmed that where staff skills in keeping people safe fell below the standard expected by the provider, steps were taken to address this. This helped ensure people were kept safe from the risks associated with unsafe care.

There were systems in place to identify risks and protect people from the risk of harm. People had risk assessments in place where there was an identified risk to their health, safety or well-being in relation to an activity or aspect of their daily living. One person showed us how adaptations had been made to kitchen equipment to enable them to make hot drinks more independently. They said, "I can make my own tea

safely." The person told us staff supported them well to remain safe, and showed us how a personal alarm worked to alert staff if they fell. Staff were knowledgeable about the person's current support needs and demonstrated, during our inspection, they were following professional guidance on helping the person to move around the service safely. The registered manager confirmed the risk assessments and associated support plans were in the process of being updated, and we saw this was happening. This meant people were protected from the risk of harm whilst being supported to do the things they wanted to do.

Accidents and incidents were reviewed and monitored to identify potential trends and to prevent reoccurrences. We saw documentation to support this, and saw where action had been taken to minimise the risk of future accidents and incidents. The provider had systems in place to record, monitor and analyse behaviour that may cause harm to people. We saw, for one person, how staff documented and reviewed their support, as there had been a number of incidents between the person and other people living at the service. The registered manager confirmed staff had sought external support from professionals for the person. This demonstrated the provider was proactively monitoring and taking steps to reduce the risks of avoidable harm through incidents and accidents.

The provider ensured that risks associated with the service environment were assessed and steps taken to minimise risks. They worked with the organisation that provided and maintained the property people lived in. Staff and records confirmed this was the case. We noted that the provider had experienced some difficulties in getting the organisation that provided the property to carry our repairs and maintenance in a timely manner. This had resulted in people having to wait longer than necessary to have improvements made to their home environment. People, staff and visiting health and social care professionals commented that the home environment needed improving. The registered manager said, and records confirmed the provider had regular contact with the organisation to push for improvements to be made. We saw new flooring was being installed on the stairs to make them safer to use, and plans were in place to upgrade kitchen facilities.

People's files contained emergency information and contact details for relatives and other key people in their lives. Each person had an individual emergency evacuation plan (PEEP) which contained detailed information on how to support them to remain safe in the event of an emergency. Staff knew what to do in the event of an emergency, and the provider had a business contingency plan in place.

There were safe recruitment practices in place. Staff told us, and records showed the provider undertook pre-employment checks, which helped to ensure prospective staff were suitable to support people receiving care. This included obtaining employment and character references, and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. They also undertook an induction period of training the provider felt essential. We saw evidence the provider set out what they expected from staff if there were issues with their skills, and took action to manage this. This meant people and their relatives could be reassured that staff were of good character and remained fit to carry out their work.

People's medicines were managed safely and in accordance with professional guidance. People felt staff supported them to manage medicines safely, and confirmed that staff recorded this. Staff told us and records showed they received training and had checks to ensure they managed medicines safely. Staff feedback and records showed they knew what action to take if they identified a medicines error. The provider had up to date guidance for staff which was accessible for staff who dealt with medicines. We saw all medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. Staff took time to explain to people what their medicines were for, and checked that people were happy to take their medicines. The provider carried out regular checks to ensure medicine errors were

minimised. They encouraged staff to report all medicine errors so action could be taken if necessary to ensure people received medicines safely. This meant people received their medicines as prescribed.

Good

Is the service effective?

Our findings

People told us staff asked them for their consent before offering support. People's care plans contained a lot of information about how they should be supported and given information to enable them to make their own decisions. For example, one person was supported to make their own day to day decisions, and their care plan reminded staff to use clear straightforward language and not, "Big words." The person confirmed they did not like staff or health professionals using, "Jargon – I don't like that." This demonstrated staff supported people to make their own decisions.

The provider worked in accordance with the Mental Capacity Act 2005 (MCA). Staff understood their responsibilities under the MCA and demonstrated this to ensure people's rights were respected. The 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people had capacity to consent to their care, this was documented, and staff respected decisions people made for themselves. Where people lacked capacity to make certain decisions, the provider followed the principles of the MCA to ensure best interest decisions were made lawfully. Staff understood the principles of the MCA, and put this into practice in their everyday work. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to provide restrictive care that amounts to a deprivation of liberty. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant supervisory bodies appropriately for four people who were deprived of their liberty had access to support to enable them to understand MCA DoLS and to exercise their rights. For example, we saw people with DoLS authorisations had regular visits from their relevant person's representative (RPR). The role of the RPR is to ensure that people can exercise their rights under the MCA, and that their care is as least restrictive as possible. People's care was regularly reviewed to ensure that any restrictions in care were legal and in proportion to any risks. The provider was working in accordance with the MCA, and people had their rights upheld in this respect.

People felt the staff who supported them had the skills and knowledge to do so. Relatives also spoke positively about staff knowledge and skills. One relative said, "They [staff] know how to support them – they've got the right approach." Staff were knowledgeable about people's individual care needs and were able to describe what level of support people needed throughout the day. The care records we looked at supported this.

One staff member spoke positively about their induction and training, stating, "Staff really helped me

[during my induction]." The provider had an induction for new staff which included training, shadowing experienced colleagues, being introduced to the people they would be caring for, and skills checks. During the induction period, staff shadowed experienced colleagues so they could learn people's individual needs and preferences. New staff undertook the Care Certificate as part of their induction, and all staff were working towards or had achieved this. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to.

Staff undertook training in a range of areas the provider considered essential, including safeguarding, medicines management, and pro-active strategies for supporting people to manage anxiety and distress. Specific training was also provided for staff working with people who had specific conditions or needs, to ensure staff had the skills and experience to support them correctly. For example, how to support people with learning disabilities and dementia. Staff told us and records showed that they received regular refresher training in areas of care the provider felt necessary to meet the needs of people at the service. Staff confirmed they could ask for additional training and evidence showed they received this where it related to supporting people to maintain their health and wellbeing. This meant people were supported by staff who had the appropriate skills and experience to provide them with the individual support they needed, at the times when they needed.

Staff used both verbal handovers and a communication book to inform each other about important aspects of people's care. We saw this information was used when staff started their shift. This meant staff were informed of any changes in people's care on a daily basis.

People were involved in planning and preparing meals. Staff supported them to go shopping for food and to develop and maintain skills in food preparation. People's care plans contained sufficient information about their likes and dislikes, and detailed information about what people could do for themselves. For example, one person said they needed supervision using the cooker as they lacked confidence, and care records supported this. People planned the house meals together and staff said they tried to ensure that everyone's preferences were respected. Five people needed additional support at mealtimes, which we saw they received. Their care plans had information detailing what support they required, and included assessments from speech and language therapy to determine what additional support they needed. During our inspection, we saw people were supported to access the kitchens in the two houses to make drinks and meals. People were supported to make their own drinks when they wanted, and staff ensured people were offered plenty of drinks and food throughout the day. This showed us people were supported to maintain a good diet and fluid intake to keep them healthy.

People were supported to keep healthy and access health care when they needed to. One person spoke about recent support from health professionals to get the right equipment for them. They described how positive this was for them and how it had made them more independent. The same person also described a recent accident, and said staff responded quickly to ensure they had medical attention. We saw from the person's care records that staff had made appropriate and timely referrals to health and social care professionals. Relatives felt confident staff knew how to ensure people had access to healthcare when they needed it. The provider had a diary that all staff used for key appointments, and a computer system enabled the registered manager to keep track of people's appointments to ensure they had support to go. Evidence showed people had attended their appointments as planned. This demonstrated people were supported to have access to health care when they needed it.

The provider had ensured people and health professionals had key information available in the event of a hospital admission. People had a document which summarised their health conditions and medicines. The document also contained clear information about how people needed to be supported and information

about effective communication. This meant when people needed to go to hospital, health professionals had information about how to support them appropriately.

Good

Is the service caring?

Our findings

People felt supported by staff who provided care in a good-humoured, friendly, dignified and compassionate way. One relative commented, "They [family member] are so looked after; so cared for. Staff are very kind and supportive." A visiting professional described people and staff at the service as being warm and welcoming when they visited without prior arrangement. People were encouraged to answer the door to visitors. Staff confirmed they promoted this as this was people's own home, rather than the staff's workplace.

People and staff had worked together to establish "house rules" that identified how people wanted others to behave in their home environment. They also highlighted how people wanted staff and fellow residents to behave towards them. This included, for example, that staff should always knock on bedroom doors, and there should be no shouting. The "house rules" poster was displayed clearly in both kitchens, and was written in a way that was accessible to everyone. People told us staff treated them with dignity and respect, and all of the interactions we saw between people and staff supported this.

Throughout our inspection, we saw staff supported people in a caring, friendly and respectful way. For example, staff communicated with people in ways which suited their communication styles. Staff asked for permission to provide any support or care, and responded promptly to requests for assistance.

People were treated with kindness and care by staff who knew them well. People told us staff were usually available to talk with if they were worried or needed support. A relative said, in their experience, staff always spoke and interacted with people in a kind and respectful manner.

People told us they were involved in making decisions about their care and support. A relative commented, "I go to reviews and always get invited. They [the service] always let me know what's happening." Staff told us they spoke with people regularly about their care and asked them how they wanted to be supported. One staff member said, "I want to be able to support people to do things they want to do." Records showed people were directly involved in reviews and discussions about their care. A visiting professional said staff encouraged people to participate in reviews and listened to people's views and opinions about their care. Care records and other documentation was made available to people in pictorial and easy read formats. This meant people were actively involved in establishing and reviewing their support, and had information given to them in ways they could understand.

People had access to independent advocacy services. An advocate is someone who supports a person to put forward their views and wishes about care and support. People at the service had support from advocates in relation to their care provision under the Care Act 2014. Staff told us an advocate supported several people, and they had raised issues on their behalf. For example, the advocate supported people to participate as much as possible in reviews of their care. A health care professional said people were supported to participate in discussions about their support, with advocacy support where this was needed, and that staff sought people's views. This demonstrated that people were supported to make their own decisions about their care as much as possible.

People told us they were encouraged and supported to be as independent as possible, subject to staff availability (if this was needed). Staff worked in ways that promoted people's independence as much as they could. One staff member commented, "We try to encourage people to do as much as they can for themselves." They gave examples of how they did this, and during our inspection, we saw this happened. We saw that those people who could go out without support did so, to take part in activities they chose. People were involved in discussions with staff about their plans for activities throughout the week.

People told us about visits to and from relatives and friends. Relatives said people were encouraged to have contact with family and friends if they wished this. Staff told us and records confirmed that people were supported to maintain relationships that were important to them. For example, one person was supported to plan a holiday with a friend. This showed people were supported to have relationships that were meaningful to them.

Requires Improvement

Is the service responsive?

Our findings

People had mixed views about the amount of support they had to take part in activities in the home and the local community. One person said, "I go out quite a bit – I like it." Another person said they did not go out much, and would like support from staff to do more things they liked. Health and social care professionals expressed the view that staff were not consistently responsive in meeting people's needs in relation to activities or hobbies that were important to them. For example, they felt, for one person, staff were not proactive enough at engaging them in activities, and could not always explain why planned activities had not taken place. They expressed concern for people who were quieter and who needed a lot of encouragement to express their views. They felt some people were at risk of not having their social needs met.

Staff felt able to meet people's key needs, such as meals and personal care, but did not always feel able to support people to go out and take part in activities in their local community as much as people wished. We reviewed records in relation to people's daily activities and found staff were not consistently recording what support was offered, and what actually happened. Although some people clearly had a range of activities and hobbies they took part in, it was not clear how other people were being supported throughout the week. Staff meeting records and a recent quality check by the provider identified that recording of activities was an area where staff needed to improve. We discussed this with the registered manager, and they acknowledged this remained an issue. We identified this was particularly in relation to people who could not go out independently, and who were less likely to express their views on this. The registered manager confirmed they would raise this with staff, and work with people to identify suitable ways of recording and showing what support they received. The registered manager said they felt they were able to meet people's fundamental needs in terms of personal care, but were not always able to support people with all the other activities as they wished. The registered manager confirmed after our inspection visit they had spoken with staff about how to support people more effectively with the numbers of staff. To improve this, the provider is reviewing support hours and how they are used with people. Where necessary, the provider will discuss the need for additional support with service commissioners. They have also taken steps to see if suitably selected and trained volunteers can be used to support people with activities. However, at the time of the inspection, the provider could not assure themselves people were being encouraged and supported to take part in a range of activities and hobbies that were meaningful to them.

People received personal care that was tailored to their individual needs. People told us staff knew them well and took time to find out what they liked and disliked. We saw there was clear and detailed recording of people's assessed needs and their views and preferences. A relative said they felt staff knew how to provide personal care to their family member in the way that was right for them. People's care plans contained information about their likes and dislikes, hobbies and friendships, and key information about life events. Where it was not possible to obtain this information from people directly, staff asked family members to provide information they felt was important about people's lifestyle choices.

Staff felt care plans contained enough information for them to be able to understand and support people's needs. People's care plans were person-centred, and included their views about how they were supported,

their goals and aspirations. This showed the provider had relevant information about people's needs in order for care to be provided.

The provider did not hold regular formal meetings with all the people together who used the service, but did this as and when an issue arose where everyone's views needed to be heard. Staff who facilitated these informal meetings recorded what the meeting was about, what people's views were and what the outcome was. In this way, it was clear people were involved in discussing issues that affected the quality of their service. This meant the provider sought people's views in ways which enabled them to express their opinions about their care and support.

People and their relatives told us they knew how to make a complaint and felt confident to tell staff if they were not happy with something. The provider had a complaints policy which was also available in an easy read format. Records showed us the provider had a clear record of complaints investigations and outcomes, and we could see where action had been taken as a result. The provider also looked at complaints on a regular basis to see whether there were any themes they needed to take action to improve. This meant the provider had a responsive system to resolve concerns and complaints.

Good

Is the service well-led?

Our findings

On our inspection of the service on 17 and 19 November 2015, we identified a number of areas of care provision that required improvement. We saw the provider had conducted a comprehensive review of the quality of care in relation to the fundamental standards set out in the Health and Social Care Act 2008, and against the guidance CQC gives to service providers. The review clarified the concerns we had raised in our inspection, and set out a clear action plan for improvements to be made. Improvements were made in respect of compliance with the Mental Capacity Act 2005, and in making notification to CQC. The provider met the fundamental standards in these areas as required.

Staff understood their roles and responsibilities, and demonstrated they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose (SOP) is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service. For example, the provider's SOP included the aim, "To assist people with a learning disability to lead independent and fulfilled lives with whatever support they require." Whilst people were supported in many ways that met the provider's aims and objectives, we found the provider could not consistently demonstrate how people were supported to enjoy meaningful occupation throughout the week.

The registered manager understood their responsibilities and felt supported by the provider to deliver good care to people. The registered manager and provider appropriately notified the Care Quality Commission of any significant events as they are legally required to do. They had also notified other relevant agencies of incidents and events when required. They monitored and reviewed accidents and incidents, which allowed them to identify trends and take appropriate action to minimise risks. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed.

Staff felt supported by the registered manager and provider. One staff member said, "The managers [registered and deputy] are good. They work hard to provide good care for residents." Staff felt able to raise concerns about the service, and were able to contribute ideas for improving the service.

The provider took appropriate and timely action to protect people and had ensured they received all necessary care, support, or treatment from external health professionals. They also monitored and reviewed accidents and incidents, which allowed them to identify trends and take appropriate action to minimise the risk of reoccurrence. For example, the provider was working the local authority to ensure one person had additional support at key times to reduce the likelihood of incidents.

There were systems in place to monitor and review the quality of the service. The provider looked for ways to improve the service for people. The registered manager and provider carried out regular checks of the quality and safety of people's care. All staff had responsibility for being involved in checks of the quality of the service, and people were also encouraged to be involved in this where appropriate. Checks included regular monitoring of people's care and the service environment, how people felt about care and regularly

seeking people's views about the service. Staff told us and records showed they had frequent communication with the organisation who owned the property. We saw evidence that any problems with the property were identified quickly and reported to the housing organisation. Maintenance of the property was ongoing and there were plans for further refurbishment.

The provider had organisational policies and procedures setting out what was expected of staff when supporting people. Staff had access to these, and they were knowledgeable about key policies. We looked at a sample of policies and saw these were up to date and reflected professional guidance and standards. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the manager and provider would take action. This demonstrated an open and inclusive culture within the service.