Oldham Care and Support Ltd

Ena Hughes Resource Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Ena Hughes Resource Centre is based in Oldham and provides care and support to people living in their own homes, either on an independent supported living basis, or as part of a shared lives scheme, where people lived with carers and their carer's families. People in receipt of care on an independent supported living basis generally received support from care staff 24 hours a day and some received enablement support by third party organisations, to access the community. The last inspection of this service was in April 2014, when the provider was found to be compliant in all of the regulations that we inspected at that time.

This inspection took place on 10 and 11 October 2016 and was announced. The provider was given a minimum of 48 hours' notice because they support people with learning disabilities and autism spectrum disorder who are often out during the day; we needed to be sure that someone would be in and also that office staff would be able to assist us. The inspection was carried out by one inspector.

Two registered managers were in post at the time of our inspection, both of whom had been registered with the Commission to manage the carrying on of the regulated activity since October 2013. One registered manager was responsible for the delivery of the regulated activity under the supported living side of the service and the other, under the shared lives element of the service. 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.

Not all of the people in receipt of care could communicate with us verbally, but those who could told us they were happy with the support they received. They said they liked the staff team or the carers who supported them and we saw they enjoyed good relationships. People told us they felt safe when they were cared for and we had no concerns about how staff or carers supported people when we visited them in their own homes.

Safeguarding policies and procedures were in place for staff and carers to follow and records showed they had taken appropriate action to safeguard people from harm and abuse when certain circumstances arose. Staff and carers were knowledgeable about safeguarding vulnerable adults and records confirmed they had been trained in this topic. Risks that people had been exposed to in their daily lives and within the environments of their homes had been assessed and mitigated against to ensure they remained safe. Accidents and incidents were dealt with appropriately and measures were put in place where necessary to prevent repeat events.

Recruitment procedures were thorough and included suitable checks to ensure that staff and carers employed to deliver care were of suitable character to work with vulnerable adults. Medicines were managed safely and reflected best practice guidance. Staffing levels were determined by the level of support each individual needed and when we visited people in their homes these levels were appropriate to people's needs.

Staff and carers were aware of people's needs and effective plans were in place to support them to meet these needs. Care plans and risk assessments were regularly reviewed to ensure they remained current and up to date. They were very person-centred and described in detail how staff should support people, the risks associated with their needs, their personal behaviour traits, their likes, dislikes and any habits. People were supported to attend medical appointments as and when necessary and specialist input into their care was evident where needed. People's conditions and their care was monitored through a range of tools to ensure that the care delivered remained appropriate and that when changes were needed these were made.

Care staff and carers were trained in key areas relevant to their role such as infection control and fire safety. They were also trained in areas such as autism awareness and deprivation of liberty safeguards, which was relevant to the needs of some of the people they supported. An induction package was in place and supervisions, appraisals and staff meetings took place regularly to provide support to the staff team. Carers told us they felt supported by the office staff and management on the shared lives scheme element of the service and said they had regular contact and reviews with them.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The service understood their legal responsibility under this act and they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken in line with procedures set out in the MCA. Applications to the Court of Protection were currently being considered by people's care managers in the local authority, and the registered managers were working with the local authority to progress these as soon as possible. People's consent to care and treatment was obtained before staff delivered care and we saw this in practice when we observed care being delivered during our visits to people's homes.

Equality and diversity was considered and respected. People were treated with dignity and respect and they were afforded privacy by care staff and carers as and when they required it. Staff were motivated and reflected pride in their work. They talked about people in a way which demonstrated they wanted to support them as much as possible and provide a high standard of care. People had differing levels of independence within the boundaries of their abilities and needs, but staff and carers encouraged them to become as independent as possible. Staff and carers provided people with explanations about their care, activities and choices available to them. Information such as service user guides were also distributed to people when they started using the service, in a format that met their needs.

People were supported to make their own choices about what they did in their lives and they pursued activities that they enjoyed. Some people enjoyed employment at local businesses. A formal complaints system was in place and feedback about the service was actively sought and acted upon.

We received positive feedback about the registered managers and overall leadership of the service. A structured management reporting system was in place which provided support to carers, care staff, office staff and all levels of junior and senior management. Meetings were held within the service internally and also within the provider's organisation at a more regional level. Quality monitoring systems were robust including a range of audits and checks being carried out in relation to health and safety matters, medicines management, finances, records and staff practice. Regular audits were carried out by the associate director of operations to ensure that the registered managers were managing and monitoring the service effectively.

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 knew how to safeguard vulnerable people from harm and abuse.

Risks that people were exposed to in their daily lives and their environments were assessed and measures put in place to mitigate these risks.

Staffing levels were appropriate to meet people's needs and recruitment of staff was robust.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People received care that met their needs. They were supported by staff and carers who were knowledgeable and who had the skills to support them safely.

People's general healthcare needs were met and they were supported where necessary to attend appointments with their GPs or other more specialist healthcare professionals such as psychiatrists.

The provider understood their legal responsibilities under the Mental Capacity Act 2005 (MCA) and this was appropriately applied.

Is the service caring?

Good

The service was caring.

People and the staff and carers who supported them, enjoyed good relationships.

Equality and diversity was considered and promoted. People were treated with dignity and respect and their independence was promoted.

People were informed about their care and included in review meetings where they were able to participate.

Records were stored securely. Advocacy services could be arranged if they were needed.

Is the service responsive?

Good

The service was responsive.

People told us staff were responsive to their needs.

The care that people received was person-centred and care records contained detailed information for staff to refer to.

A formal complaints policy and procedure, and feedback systems to gather the views of people who used the service, staff and carers were also in place.

Is the service well-led?

Good

The service was well led.

The registration requirements of the service were met.

The provider had a clear mission statement which staff were committed to achieving.

People, staff and associated healthcare professional gave positive feedback about the leadership of the service.

Auditing and checks were carried out regularly to ensure that any shortfalls in the service were identified promptly and addressed.

Ena Hughes Resource Centre

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 inspection took place on 10 and 11 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a supported living and shared lives service for adults who are often out during the day; we needed to be sure that people would be in, and staff would be available to assist us. This inspection was carried out by one inspector.

Prior to our inspection the provider completed a Provider Information Return (PIR). A PIR 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 reviewed all of the information the provider submitted, plus information that we held internally about the service, including statutory notifications that the provider is legally obliged to inform us of. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We also sought feedback about the service from Oldham Council Contracts and Commissioning team. We used the information that they provided us with to inform the planning of this inspection.

During our inspection we spoke with four people who used the service, although only three people were able to communicate with us verbally. We also spoke with the registered managers, associate director of operations, associate director of quality and performance, two resource managers, four care workers and two carers. During our visit we looked at seven people's care records, Medication Administration Records (MARs) and a range of other records related to the operation of the service. These operation records included looking at six staff training and recruitment records, care monitoring tools and quality assurance documentation.

Good

Is the service safe?

Our findings

People reflected that they felt safe when being supported by staff or their carers. They told us they had not been mistreated and that they had not been spoken to inappropriately. One person said, "The staff are always nice". Another person told us, "Sometimes (carer's name) tells me to not be so loud, but that's because I talk a lot and they are trying to watch telly!"

When we spoke with staff they were aware of their own personal responsibility to report any matters of a safeguarding nature. Staff and carers had been trained in the safeguarding of vulnerable adults. Records of historic safeguarding incidents showed they had applied what they had learned and taken appropriate steps to protect people. The provider had safeguarding and whistleblowing policies and procedures in place that provided staff with the guidance they needed to escalate any concerns of a safeguarding nature, should they arise. A flow chart diagram was in place to aid and inform staff about the reporting channels they should follow, both internally and externally when relaying concerns to the local authority safeguarding adults team in line with set safeguarding protocols. The registered managers retained detailed records about any on-going or historic safeguarding matters, including outcomes, and these records showed they worked well with the local authority safeguarding team to progress and conclude investigations.

We had no concerns about how staff supported people through our own observations of care; they treated people respectfully and delivered care that was both appropriate and safe. People appeared settled within their homes and they had access to staff, or carers, 24 hours a day to meet their needs. Risks that people were exposed to in their daily lives had been assessed and plans put in place to mitigate these risks as much as possible. For example, people had risk assessments in place related to walking in the community, taking medication and bathing. There was detailed information about the hazards involved in each activity, who or what may be harmed, what is already in place to reduce these risks, any further actions to take and who will do these and by when. Records showed that risk assessments were regularly reviewed to ensure their content remained current, in line with people's changing needs. Specific detailed strategies were also in place for staff around for example, how to communicate with people effectively and how to support people to the toilet. These strategies also reduced the risks that people faced.

Accidents and incidents that occurred within the service were appropriately recorded, dealt with and monitored. An incident reporting policy was in place and records showed this had been followed in practice. Details of each individual accident or incident had been recorded including what happened, who was involved, what support was obtained and who was informed. This showed the provider responded to accidents and incidents appropriately to ensure people remained as safe as possible. The associate director for quality and performance told us that an analysis of accidents and incidents was to be introduced to ensure that any emerging patterns and trends were identified and then measures put in place to prevent repeat events.

Staff supported people to monitor health and safety matters and risks within their homes by carrying out checks on the environment and any equipment, including fire safety checks. Emergency planning had been considered and a business continuity plan was in place for staff to refer to in the event of an emergency

situation. People on the supported living side of the service had a Personal Emergency Evacuation Plan (PEEP) within their care records which listed the support they would need to evacuate their homes in an emergency situation such as a fire or flood. An on-call system and contact details for management at a variety of local and senior levels was available to staff and carers, should they need support outside of core working office hours.

Staffing levels within the service were determined by people's needs and staff were allocated to each property where people lived on the independent supported living side of the service. In the shared lives scheme, people were cared for by the carers with whom they lived. Staffing levels were appropriate in the properties that we visited where differing numbers of people lived. On the independent supported living side of the service a keyworker system was in place, although all staff supported all people at varying times. Some of the people received 2:1 support from staff, in line with their needs, others 1:1 support but this could vary depending on the activities they undertook. Staff told us that the number of staff on duty was sufficient to meet people's needs and they got support from the management structure above them when needed.

Evidence in staff files demonstrated that the provider's recruitment and vetting procedures of new staff were appropriate and protected people. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs were met by staff who were of good character and who had the appropriate competence and skills to carry out their jobs.

The management of medicines was both appropriate and safe. Medicines administration records (MARs) were well maintained and reflected that the recording of the administration of medicines was in line with best practice guidance. Medication care plans were individualised and described how people liked to take their medicines and what involvement the service should have in the administration process. Personalised plans were in place for the administration of 'as required' medicines (PRN medicines) detailing when these should be given to those individuals who required them, for example, when they displayed specific behaviours or signs of pain that may indicate that these medicines may be needed. They also listed the strategies that should be tried before PRN medicines were administered. All of the medicines we checked were within their expiry date and stored in line with manufacturers guidelines. Systems were in place to account for and dispose safely of medicines that were no longer required. People were supported by staff and carers to have their medicines reviewed by their GPs on a six-month or annual basis depending on their needs. Audits and checks on how medicines were handled within the service were carried out, as were checks on staffs' competency in handling medicines. This ensured people received appropriate support to take their medicines safely.

Good

Is the service effective?

Our findings

People gave us positive feedback about the service they received. One person told us, "The staff are good they help me with what I need". Another person told us, "I am happy with (carer's name). They look after me".

We were satisfied that people received a good service and their needs were met in a timely manner. Staff and carers were clear about people's needs and how to support them appropriately. When we asked staff and carers about the needs and behaviours of particular individuals, they were able to explain these in detail to us and they clarified how they would support these people effectively. The information they gave us tallied with information held in these people's care records and our own observations.

People's general healthcare needs were met. We found evidence that people were supported to access routine medical support, from for example their GPs and dentists. Staff and carers also supported people to access more specialist support, such as that from a psychiatrist, where they needed or wanted this level of support. Some people had nutritional needs associated with their health conditions that were well monitored by staff and carers. For example, some people had diabetes and where necessary their food intake was monitored. They were also supported to cook their meals and attend appointments with relevant healthcare professionals for regular reviews of their conditions. One person had difficulties and anxieties around swallowing food. We saw they had been supported to access speech and language therapy services. People were also weighed regularly to ensure that any significant changes in their weight were identified promptly and medical attention sought. Some people planned their meals and then shopped locally for their food with support from staff. Staff purchased food for other people who were less able, in line with their likes and dislikes, which staff had established whilst caring for them.

Staff and carers told us that communication within the service was good and they had enough information available to them in people's care records to meet their needs effectively. Staff meetings took place regularly and handover meetings to ensure that key messages were passed between different changing staff members when they came on shift. Carers said they received appropriate support and communications from the service.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We discussed the MCA and Court of Protection orders to deprive people of their liberty in a domiciliary setting with the registered managers and associate director for operations. They told us that people's

cognitive abilities were assessed at the point the service commenced and then afterwards, as and when necessary, related to individual decisions being made. Management were clear about their responsibilities in line with the MCA. We saw several examples of best interest decision making where mental capacity assessments had been carried out and then a communal decision made. These included, for example, best interest decisions made about people going on holiday and changing accommodation type. Comprehensive records were retained about the decision making process and who was involved. The registered managers confirmed that no person currently using the service was subject to a Court of Protection order to deprive them of their liberty in a community care setting. They confirmed that any potential need for DoLS applications to be made via the Court of Protection, were currently being considered by people's care managers based within the local authority. Records showed the registered managers were working in partnership with local authority care managers to progress these applications as soon as possible.

People's consent was sought in respect of the care they received. During our visit to people's homes we saw that they were always asked if they wanted to do something or if they could assist staff and carers with a task. There was no evidence that people were encouraged to do something without their consent first being obtained and people confirmed this did not happen.

Staff told us, and records showed that they received regular training relevant to their roles. Staff training requirements were monitored by the registered managers and arrangements were made for training to be refreshed as and when required. This ensured that staff were supported to deliver effective care as their skills were kept up to date. Staff had completed training in a number of key areas such as the safe handling of medicines and safeguarding vulnerable adults, as well as some specialised training relevant to their roles, including epilepsy awareness and autism awareness. One member of staff told us, "Our training is good. I think I have been trained in everything that I need to be". An induction programme was in place and completed by new members of staff at the point they commenced employment with the service. Work was being undertaken to embed the Care Certificate into this induction for all new staff. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and brought into force in April 2015. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers. This showed the provider invested in their staff team and supported them to maintain and develop their skills.

Staff told us, and records confirmed that supervisions took place regularly and appraisals annually. Supervisions and appraisals are important as they are a two-way feedback tool through which managers and individual staff can discuss work related issues, training needs and personal matters if necessary.

Good

Is the service caring?

Our findings

The relationship between people who used the service and the staff or carers who supported them was good. Carers on the shared lives side of the service told us the people they cared for were an integral part of their families and people themselves confirmed this saying they felt completely supported and welcomed by the carers and their relatives in their extended families. Some people had been living with their carers for over 20 years and said their lives together were "great!" One person told us, "I love it here. (Carer's name) is great. Today we are going to see (carer's name) niece and I will hold her new baby". Another person described their placement with a carer as "wonderful". They said, "It is fantastic here and I have changed into a different person since I have been here. I didn't used to go out but now I go out with friends and the family all the time".

When we visited people in their own homes we observed the approach staff and carers had to supporting people. We found they were caring, thoughtful, polite and respectful. They understood the people they cared for and their needs. Staff, carers and people enjoyed jovial exchanges and appeared comfortable in each other's company. Staff and carers talked about people's personalities and how they had learned to understand their expressions and feelings, where people were not able to communicate with them verbally. We observed people showed affection towards staff.

Our discussions with staff revealed there was one person in receipt of care from the service with a diverse need in respect of their religion under the seven protected characteristics of the Equality Act 2010 that applied, namely; age, disability, gender, marital status, race, religion and sexual orientation. This related to eating halal meat and records showed this person should always be provided with halal meat, which was specifically bought for them. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. Staff had received training in equality and diversity and they were knowledgeable about treating people equally and in line with their own individual and differing needs.

Staff were motivated and reflected pride in their work. They talked about people in a way which demonstrated they wanted to support them as much as possible and provide a high standard of care. People were treated with dignity and respect, for example, staff knocked on people's bedroom doors before being invited to enter, so that their privacy was respected. Staff gave us examples about how they protected people's dignity where their behaviours compromised this. One person who lived with a carer told us they had their own personal space and could retire to their bedroom at any time to be alone should they want to.

The ethos of the service, and the nature of independent supported living and shared lives schemes as a support model, naturally lend themselves to promoting people's overall independence. There was evidence that people had progressed in their abilities to look after themselves as a result of receiving care and support from the service and that their needs and behaviours had changed. One person told us they were able to do things with greater independence since moving to live with a carer and their family. People had differing levels of independence within the boundaries of their abilities and needs, but staff and carers

encouraged them to become as independent as possible.

Staff and carers provided people with explanations about their care, activities and choices available to them. They communicated with people well throughout our visit and explained what they were doing when directly supporting people with their care. In terms of the information that people received, the organisation issued 'Service user guides' for people whether they accessed the service under the independent living model or shared lives scheme. These gave people information about the services available to them and how they would be supported. They were available to people in pictorial format in line with their needs. People were also involved in reviews about their care where they were able to participate in these conversations.

The registered managers confirmed that no person in receipt of care currently accessed the services of a formal advocate, but should this be needed, it would be arranged via their care managers in the local authority. An advocate is a person who speaks up on behalf of another person, to ensure their views and wishes are expressed and their voices heard. They always act in people's best interests where people do not have the capacity to express their own views.

Records were stored confidentially and conversations were held with us discreetly where necessary during our visit. This showed the staff and carers were mindful of confidentiality.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs and supported them in any way they needed them to. One person told us, "The staff helped me to go shopping and choose things for my flat. They help me cook too". Another person said, "My carer is great. They help me if I need them to".

The care people received was person-centred by the very nature of it being an independent supported living service and shared lives scheme. Staff and carers described how they cared for individual people in respect of their differing needs and behaviours, and what they told us tallied with information contained within people's care records about how to support them. People described what they were going to do on the days that we visited. They had made these choices themselves in line with what they wanted to do. Staff told us this was the way the service operated because they were there to facilitate people living their lives in the way they wanted to. We saw, and people told us they had choices about all aspects of their lives, from the food they ate, to where and how they spent their time. When we visited one person in their home we saw they changed their mind about the form of transport they were going to use on a visit out into the community several times and these choices were encouraged and respected by staff. One person told us they worked at a local garden centre twice a week and that they enjoyed this work. People were supported to pursue activities of their choosing.

Each person had care records in place that were person-centred with elements written in the first person. These provided staff with a range of information about the person, their needs and any risks that they may be exposed to in their daily lives. For example, there was information and person-specific strategies in place about how to communicate effectively with each individual, what certain behaviours they displayed may mean, triggers for certain behaviours, and pen pictures about their life history and daily routines, amongst other things. Risk assessments, and steps that needed to be taken to mitigate risks, were clearly documented and there was a wealth of information about how to support each person effectively. External healthcare professionals' involvement in people's care was evident and where professionals such as clinical psychologists had produced guidance about how to support people, this had been retained within their care plans and formulated into the care plans and risk assessments developed by the service. Care records were regularly reviewed and updated as people's needs changed.

Care monitoring tools such as records tracking people's moods, behaviours, weights, food intake and any incidents or accidents, were in place and well maintained. This meant there was a constant oversight of people's care needs and changes could be easily and promptly identified. Verbal handover meetings were also carried out when each staff shift changed so that any important information and any key issues to follow up, was transferred to the oncoming shift. Daily notes about people's moods, behaviours, activities, appointments and any further important information were well maintained and informed the reader about what that person's care had looked like that day. A staff communication book was also used by staff to relay important messages. This showed the provider had systems in place to ensure continuity of care as much as possible and to monitor and track any changes in people's needs as promptly as possible.

A formal complaints policy was in place which detailed how a complaint could be raised, how it would be

handled and listing the timescales involved. A matrix showed that nine concerns or complaints had been received by the service in the 12 months prior to our inspection. Records were retained about individual complaints and these demonstrated that matters had been appropriately investigated and letters sent to complainants with an outcome and where appropriate, an apology. We were satisfied that the provider responded to and acted on complaints and concerns that were raised.

Systems were in place to gather feedback from people, staff and carers. A 'My life, my review' questionnaire was completed annually by people who used the service and on the shared lives side of the service this often involved people coming into the service's office base for a 'chat and a brew', as management referred to it. We saw these questionnaires asked people to provide feedback about their satisfaction levels including details about anything that they did not like. The associate director for quality and performance told us that an annual staff survey had recently been introduced to gather the views of staff anonymously. Carers from the shared lives scheme operated by the service had fed back that they received excellent support with professionalism, and that the management team have listened and acted whenever they had taken any matters to them. Other channels for feedback within the service existed in the form of supervisions, appraisals and meetings for staff and review meetings for carers and people who used the service.

Good

Is the service well-led?

Our findings

Two registered managers were in post at the time of our inspection who each managed a separate area of service provision, namely the supported living element of the service and a segregated shared lives function. Both managers had worked at the service for many years and both had been registered to manage the carrying on of the regulated activity at the service since October 2013.

The registration requirements of the service were met and we were satisfied that overall notifications about deaths and other incidents were made in line with requirements. We found a small number of incidents had not been notified to us as the result of a management and systems oversight. We discussed this with both registered managers, who took prompt action and submitted these notifications retrospectively the day after our visit.

We recommend the provider reviews and re-familiarises themselves with the requirements of Regulation 18 of the Health and Social Care Act 2008, entitled Notification of other incidents.

The provider's mission statement reflected a desire to provide high quality care. It declared an aim of 'Supporting people to get the most out of life' and a priority which read, 'Our priority is the outcome delivered to the people we care for'. The organisation values were listed as 'Head - we use our knowledge and expertise to deliver high quality outcomes', 'Heart - We are compassionate, caring and respect people's wishes' and 'Hands - We safely deliver high quality care and support, paying attention to detail in all that we do'. During our inspection we found a culture amongst management and staff that reflected these values and aims, and a desire to improve people's lives. The service had recently been awarded an accreditation from the National Autistic Society for their work with people living with autism and the positive outcomes they had achieved for these people.

People, staff and carers on the shared lives element of the service gave us positive feedback about the management and leadership of the service. People said that the registered managers were nice and they could speak to them when they visited their homes. Carers and staff told us that they felt supported by management whom they could approach at any time and they received the direction they needed to fulfil their roles. Healthcare professionals linked with the service told us that they enjoyed good working relationships with management and any care staff that they engaged with.

The service had a structured management system in place. The registered managers were supported by resource managers and care staff in the delivery of the service. They reported to an associate director of operations above them, who in turn reported to the managing director of the provider's company. The registered managers told us that the associate director of operations provider visited the service regularly and was fully involved in the service. They were present throughout our inspection were knowledgeable about the service delivered and the needs of people in receipt of care. All of the staff team including the registered managers confirmed the structure and levels of support within the provider organisation were very good.

Staff meetings at a variety of different levels took place regularly including senior leadership team meetings. The registered managers kept staff informed about important matters and changes to the service; staff confirmed this. The provider also used these meetings to deliver messages to the staff team. Daily handover meetings took place between care staff on the supported living side of the service to ensure that staff were kept up to date with any changes and important information in a timely manner. Accountability was evident within the service as entries made in communication books and, for example, reviews of care records and changes in instructions or policies had been read, and signed as read, by staff. People's personal care records and information was stored securely.

Quality monitoring systems were in place to ensure that the service delivered was effective and issues were identified and improved where necessary. For example, in terms of staff practice medication competency assessments were carried out. Staff performance was also assessed and monitored through regular supervision sessions and annual appraisals. A range of different audits and checks were carried out to monitor care delivery and other elements of the service. On the supported living side of the service audits were carried out monthly in each property where care was delivered and these looked at infection control, medication, complaints (if any), care records and observations of staff practice. On the shared lives side of the service 12-weekly visits were undertaken by the resource manager to review the care package in place and check the support offered by carers to people in receipt of care. Records related to these visits were basic but a more formal tool to evidence the level of auditing and checks carried out at such visits was under development. Plans were in place to introduce a formal analysis of accidents and incidents, safeguarding and complaints in order to identify any trends and patterns that may need to be addressed or lead to a change in practice or policy. The associate director for quality and performance told us that the provider planned to standardise quality assurance processes across the service and other areas of the provider's overall business.

Health and safety audits/checks around people' homes were also carried out regularly. There was evidence that where issues were identified through auditing, action plans were created and steps had been taken to ensure matters were addressed. For example, we could see that tasks had been allocated to specific staff members and a date for completion of these tasks had been set. The associate director for operations carried out their own documented 'Director's visit' at regular intervals, which reviewed the overall quality of the service delivered, in a range of different supported living establishments. The registered managers also used a range of matrices to monitor, for example, staff training and recruitment. This showed that systems were in place to monitor the service delivered and to address any shortfalls and drive improvements, should this be necessary.

A new quality group had been recently introduced into the service where registered managers from across the provider's organisation came together monthly to discuss best practice and issues on a corporate level. Staff forums had also taken place with the managing director and one other member of the senior leadership team designed to open communication channels within the organisation and obtain feedback from staff. Members of the senior leadership team and the managing director, were involved in local community consortiums, safeguarding adults boards and other specific community groups relevant to the care and service delivered, such as groups centred around people with autistic needs. This demonstrated the provider's community involvement.

The provider had recently introduced a staff newsletter which reported on recent events and changes within the service. Staff's contribution to the service was recognised through an award scheme introduced in April 2016, which identified staff who had demonstrated leadership skills, were 'unsung heroes', who had made a difference and who had acted as a role model. Staff also had access to a local council benefits scheme. The staff recognition and benefits schemes had a positive impact on staff morale.