Tracscare Wellcare Lifestyles Limited

Isle of Wight Supported Living

Inspection report

Unit G, Innovation Centre
St Cross Business Park
Newport
Isle Of Wight
PO30 5WB

Tel: 01983527023
Website: www.embracegroup.co.uk

Date of inspection visit:
01 June 2017
08 June 2017

Date of publication:
11 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 8 June 2017 and was announced. The service was given 24 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be available in the office.

Isle of Wight Supported Living provides personal care and support to people with a learning disability in seven houses providing 24 hour support. At the time of this inspection they were providing a personal care service for 28 people with a variety of care needs.

The service had a registered manager. 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 registered manager oversaw the running of the service and was supported by team leaders who were allocated a geographical area to manage.

People, relatives and staff spoke positively of the management. There were systems in place to monitor the quality of the service however, these had not been fully effective and had not identified the concerns we found within the safe and effective domains of this report. The provider's systems had failed to ensure that where a person who lacked capacity was making decisions which were harmful placing them at risk, staff had failed to assess their mental capacity to understand the implications of their decisions. Risk management guidance from an external health professional was not being followed. This was placing the person at risk.

Risk assessments and support plans had been developed with the involvement of people and their relatives. However, not all risks to people's health and welfare had been managed safely.

Staff knew about people's individual capacity to make decisions and supported people to make their own decisions. However, staff had failed to ensure that when a person made unsafe or unwise decisions they had the mental capacity to make these decisions and understand the consequences of them.

Staff understood how to protect people from abuse and were responsive to their needs. People were protected against the risk of abuse, and checks were made to confirm staff were of good character to work with people. There were sufficient staff to meet people's diverse needs and people were supported to take their medicine as prescribed.

Staff understood people's needs and abilities and knew people well. The delivery of care was tailored to meet people's individual needs and preferences. People were generally well supported to maintain good health.

Staff were provided with a comprehensive induction and ongoing training to support the people they

worked with.

The registered manager and provider's management team actively sought and included people and their representatives in the planning of care. There were processes in place for people to express their views and opinions about the service provided.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all risks to people's health and welfare had been managed safely.

People's needs were met by sufficient numbers of consistent staff. Recruitment procedures were followed to ensure staff were safe and suitable to work with people.

Staff had received training in safeguarding adults and were aware of how to use safeguarding procedures.

There were safe medication administration systems in place and people received their medicines when required.

Is the service effective?

Requires Improvement

The service was not always effective.

Formal assessment and best interest decisions were not in place for some people who lacked the mental capacity to make some decisions relating to how they were cared for. Where people had made unsafe decisions staff had not acted in their best interests to ensure their safety.

Staff usually knew people's needs and records showed most people received appropriate food and drinks, personal and health care.

Systems were in place to ensure staff received training, support and supervision.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were kind and caring. Staff had built good relationships with the people they provided care for.

Staff respected people's privacy and dignity. People were

involved in decisions about their care and lifestyle and that they were encouraged to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

People told us the care they received was personalised and people's needs were reviewed regularly to ensure this remained appropriate for the person.

The provider and registered manager sought feedback from people and made changes as a result. An effective complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems had not ensured that all aspects of the service were monitored and people were consistently receiving care in a safe planned manner.

People were encouraged to share their opinion about the quality of the service to enable the provider to identify where improvements were needed.

Staff understood their roles and responsibilities and were given guidance and support by the management team.

Isle of Wight Supported Living

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 the 1 and 8 June 2017 and was announced. Forty-eight hours' notice was given because we needed to make sure that the people we needed to speak with were available. The inspection was carried out by one inspector.

Before the inspection, we checked information we held about the service and the service provider, including registration reports and notifications about important events which the provider is required to tell us about by law.

We visited nine people who were receiving a service and viewed records held in their homes. We also spoke with two relatives of people who were receiving a service and one local authority social care professional. We spoke with the registered manager, one office based staff member, four team leaders and seven care staff. We looked at care plans and associated records for seven people, staff duty records, staff recruitment and training files, policies and procedures and quality assurance records.

This was the first inspection of the service since it was registered at this location in January 2017.

Requires Improvement

Is the service safe?

Our findings

People told us they felt the agency provided staff who kept them safe whilst supporting them with personal care. One person said, "Yes I'm safe". Another person said "yes very safe" and went on to say they liked their staff. We saw other people were relaxed and at ease with staff when we visited them in their homes. A family member said, "Yes I think [relative's name] is safe, very safe". Another family member said, "Safe, yes definitely, I see them every week and they are happy."

Risk assessments were undertaken for any risks to people and to the care staff who supported them. These included environmental risks and any risks due to the health and care needs of the person. Where needed, risk assessments were available for nutrition, medicines and community activities. Where risks were identified there was guidance for staff as to how to reduce risks to people and themselves. In the majority of instances risks corresponded to other information in people's care files and was consistent with care provided.

However, for one person we identified that the risk of choking was not being managed as per the guidelines provided by an external specialist and this was placing the person at risk. In 2016 a Speech and Language Therapist (SaLT) had undertaken an assessment and provided advice about what would be safe for the person in terms of the type and texture of their food. This information was included in the person's care plan, however, other information in the care plan about how the person's nutritional needs should be met did not include this information. Records of meals the person had received included meals and food items which would have increased their risk of choking and should not have been provided according to the SaLT guidance. One staff member caring for the person was unable to tell us about the SaLT guidance and described providing food which did not correlate to the guidance. Another staff member was more aware of the risks and how these should be managed. The registered manager and team leader agreed to take immediate actions to ensure the person would be safe. They subsequently notified us that a request had been sent to the SaLT team for a review of the person's management guidelines which they felt could be less restrictive. All team members were required to review information relating to how the person's meals should be provided.

Staff understood their safeguarding responsibilities. A safeguarding policy was available and care staff completed formal safeguarding training for adults as part of their induction. Staff members were able to recognise signs of potential abuse and understood the relevant reporting procedures. All staff we spoke with knew what action they should take if they suspected one of the people they supported was being abused or was at risk of harm. One staff member said, "I would make sure the person was safe and reassure them. Then I would check the details and contact my line manager." They added that they would also make a written record of everything and were aware of whom to contact either "higher up" in the organisation or externally such as social services. Other staff also said they would contact their line manager and be guided by them. Team leaders and the registered manager knew how to use safeguarding procedures. They were able to discuss the actions they would take if various situations arose.

Everyone receiving a personal care service required 24 hour support with staff available at all times. Staffing

levels within individual houses were determined by the number of people living there and their needs. Core hours were provided in each house and individual people had been assessed by the local authority for the number of individual support hours they required. Systems were in place to record and demonstrate that individual support hours were provided as commissioned. The registered manager told us the service was fully staffed and, although agency staff were used this was now only required on vary rare occasions. Family members told us they felt staff were consistent and they usually saw the same staff when they saw their relative. People also told us they were supported by consistent staff and in some houses staff had worked with the same people for many years. We viewed duty rosters which showed that any additional shifts required by staff holiday or ill-health were usually covered by existing staff or the services 'bank' staff who knew the people well. This meant people received the care they required from staff who they knew and who knew them and what support they needed.

There were safe medication administration systems in place and people received their medicines when required. People told us staff gave them their medicines and were happy with this arrangement. Care plans included specific information to direct care staff as to how people should be supported with their medicines and included an assessment to see if people could do this independently. Care files also contained a list of medicines people were prescribed. During induction care staff received training about how to support people with medicines. Following training, staff competency was assessed and this was reassessed every year. Staff said their training had included how to complete the Medication Administration Records (MARs) and how to check the medicines they were giving were the correct ones. Medicine records viewed were all fully completed. People's medicines records were checked at each staff handover so that errors would be picked up quickly. A team leader told us that if an error occurred supervision was had and staff may be referred to complete training again.

Recruitment procedures ensured staff were suitable to work with vulnerable people. One staff member told us, "Before I started work I had to wait for the references and police check to come back." Staff files included application forms, full work history, records of interview and appropriate references. Checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults and that staff members were entitled to work in the UK.

The service had a business continuity plan in case of emergencies and within individual houses we were told of their plans for emergencies. This included eventualities such as the risk of severe weather which may prevent staff arriving for work. All staff were clear that they would not leave a house until their replacement staff had arrived. Staff also told us that if severe weather were forecast they would make sure there were adequate supplies of food in place. For other emergencies, such as fire there were personal evacuation plans in place, systems to detect fires and arrangements for staff as to what they should do. Staff had completed first aid training and were aware of how to respond should a medical emergency occur.

Requires Improvement

Is the service effective?

Our findings

People and their relatives felt care staff were effective and they were confident in their ability to meet people's needs. A relative told us, "The staff do seem to be able to look after [relative's name] and understand [their] needs". Relatives also said they would recommend the service to another person who needed support. People were confident that staff had the skills to meet their needs.

People said they were always asked for their consent before care was provided. One person said, "Yes, they [care staff] ask me". Staff said they gained people's consent before providing care. One staff member said, "I always ask first and tell them what I'm doing".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had an understanding of consent, however, formal assessment and best interest decisions were not in place where these were required. In one care plan we read that the person should not be given a drink for 20 minutes following a meal. We asked why this was and how this had been agreed. The registered manager and care staff confirmed the person lacked the capacity to understand and agree to this. Neither the registered manager, team leader or staff caring for the person could explain the rationale for this decision or how it had been agreed. This meant restrictions were being placed on the person without their agreement or any understanding by staff of why this was required.

Staff described the process to follow if they were concerned a person was making decisions that were unsafe. Staff were aware that if people understood the decision they were making then the person had the right to continue to make the unsafe decision and that they would contact the team leader or office staff for guidance if required. However, when we discussed decision making in one house staff were less clear about their responsibilities should people make unsafe decisions. One person's care plan stated they had an intolerance to some foods, was on medicines to counteract a high cholesterol level and required other foods to be provided in a particular format for their safety. Staff said the person 'chose' some foods which may not be suitable and records showed these were provided. Staff agreed that the person lacked the mental capacity to make this decision as they would not be able to understand the effects of the food on them which may have negative effects on their health. This meant staff were failing to ensure the best interests of the person were being met and their physical health was being put at risk. Staff had not considered the persons mental capacity to make specific unsafe decisions placing them at risk.

Care plans lacked formal mental capacity and best interests decisions where staff were making decisions for people who were unable to make these decisions themselves. The registered manager showed us new care planning documentation which was about to be introduced by the provider. This included a section to direct staff to consider if any mental capacity assessment and best interest decisions were required for the

specific aspect of care that was being planned. Once introduced these forms would ensure staff considered more formally the mental capacity of people to consent to care.

We recommend that the provider reviews their documentation and record keeping to ensure they are following best practise and the Mental Capacity legislation to support people who may not be able to make all decisions themselves.

For individual safety reasons some people required a high level of support when accessing the community and some restrictions were in place. These included the use of specialist harnesses for cars, door alarms to alert staff people may be leaving their flats at night and procedures that people would always be supported when out in the community. 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. The application procedures for this 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 was being met. We found external guidance had been sought from the local authority lead for mental capacity and DoLs. Individual meetings had been held and these had determined that the procedures in place to protect individual people were the least restrictive necessary to keep them safe and their legal rights had been ensured.

People told us staff helped them prepare their meals which we saw occurring when we visited some houses. Care staff involved in the preparation of food told us they would always ask the person what they wanted. We observed staff interacting positively and respectfully with people, supporting them with choosing and preparing lunch. Care plans contained information about any special diets people required and about specific food or drink preferences and records of food and drinks people received were kept. For the majority of people there were no concerns with the way their nutritional needs were met. People were receiving a varied diet that met their individual preferences with staff helping people to make healthy decisions. However, as identified in other sections of this report we found one person was not receiving a suitable diet for their individual needs.

People's health and personal care needs were generally well met because staff knew people's needs and were able to describe how to meet them effectively. For example, when we visited one house we were told a person was not their usual self. They were unable to say what the problem was however staff felt their behaviour indicated an ear infection and had arranged a doctor's appointment for later that day. In another house one person was unwell and staff were supporting them to rest in bed. Discussions with staff showed they understood the person's health needs and medical advice had been sought. In a third house we met a person who had recently been discharged from hospital following surgery. Staff were providing additional support for the person and confirmed the person was receiving regular pain relief to counter any post-operative pain. During the visit staff identified that the person required some additional topical cream to counter a problem that developed whilst they were in hospital and arranged to get a prescription. These examples showed that staff knew and took any necessary action to meet people's health needs.

Care files contained an information sheet which included people's personal details, medicines, next of kin and a hospital passport which included essential individual information about the person and what they like and dislike. Staff told us this was used if people were admitted to hospital or an alternative care setting. These would help ensure people's needs would continue to be met if they required urgent medical care within another setting. Care files also contained health action plans which included information about people's previous health needs and showed people were supported to attend regular medical, dental and optician appointments.

Staff were aware of the action they should take if a person was unwell. Care staff confirmed they had received first aid training and additional training to meet the needs of any specific health needs individual people may have. For example, when we visited one house a person told us how staff were supporting them following a change in their diabetes management. Staff told us they had received training to support the person who was now self-administering insulin daily. Staff recorded the care and support they provided and a sample of the care records demonstrated that care was delivered in line with the person's care plan.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. People and their relatives were confident that care staff had the skills to care for them effectively. One relative said, "They [care staff] seem well trained". Newer care staff told us they had received an induction which prepared them fully for their role before they worked unsupervised. New staff completed a range of theoretical and practical training which was followed by at least two weeks shadowing experienced staff. A new staff member said, "I had extra shadow shifts as I had not done this sort of work before and then was asked if I felt ready".

During their induction new staff completed formal training and commenced the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. Staff were positive about the ongoing training they received to maintain their skills and knowledge. They confirmed this was provided by a mixture of on line self-directed training and group practical training such as for first aid or moving and handling. Staff told us they were also supported to achieve formal qualifications in care.

People were supported by staff who had supervisions (one to one meetings) with their line manager and an annual appraisal. One staff member said, "There are supervisions with my team leader about every two months". Records of supervisions and appraisals showed the process used was formalised and covered all relevant areas. When necessary actions for improvement were identified and followed up. Team leaders regularly worked some care shifts alongside care staff which they identified, enabled them to monitor and supervise staff informally to ensure they put training into practice.

Good

Is the service caring?

Our findings

People and relatives said staff were caring and they had a good relationship with them. They consistently reported a kind and caring approach relating to staff having a caring attitude, respecting dignity and maintaining independence.

We saw people appeared comfortable with staff and they told us they liked the staff. For example, when we visited one house staff offered us a hot drink. A person was present and said to staff "What about me". This showed they felt able to say what they thought to staff who responded appropriately checking if the person wanted tea or coffee. In another house we were talking with a staff member. A person came and took the staff member's hand dragging them away. This showed that although they were unable to do so verbally the person felt confident to assert their opinions. One person said, "They [care staff] are nice". In another house all people told us they liked their care staff. A relative told us, "[name person] always seems happy when they bring him to visit us". Another relative told us how the service was caring towards them as well as their relative. They told us, "When I visit they also ask how I am".

People were treated with dignity and respect and supported to enjoy a lifestyle of their choosing. We saw that people were supported to be appropriately dressed and well-presented and that conversation between care staff and people was easy, comfortable and familiar showing that staff had a good knowledge of people's likes and dislikes. It was evident all people were supported to have active lifestyles and were members of various social clubs and groups within their local community. Care staff facilitated additional events and we were told about local events they had enjoyed. Care staff were flexible and would work different hours to support people to attend evening activities. For example, one person had been supported to visit a national cricket game in Southampton and not returned until late at night. Another person told us they were going to see a premier league football match in Portsmouth. People were supported to enjoy holidays either with staff alone or with staff and other people they lived with, or social groups they attended.

People's spiritual needs and wishes were met and we saw that some people were supported to attend Church on Sundays. We were told how staff had ensured that a person had received the appropriate spiritual support when they had neared the end of their life. A staff member had remained with the person at hospital and ensured a priest had visited to provide final prayers as required by the person's religion. This meant the person had not died alone and they had received all necessary spiritual care with a known person to support them. Staff had also ensured that the person had received the type of funeral service required and respected the person's wishes including clothing they were wearing. A section within care plans included any specific end of life needs or wishes people may have meaning these would be known and could therefore be supported should the person die.

Care staff said they always kept dignity in mind when providing personal care to people. Care staff described how they would close curtains or doors and ensure people were covered with a towel when appropriate. Information about any gender preferences of care staff was included within care plans and known by care staff. People said care staff consulted them about their care and how it was provided. One person told us,

"They ask me".

Care plans were detailed and individual and showed people and relatives were involved in the planning their care. Where possible people were supported to make decisions about their homes. People told us about house meetings where things were discussed and confirmed they were included in decisions such as redecoration of shared areas. When one group of people needed to move to a new house staff supported them to visit the new house and to make choices about room colours, which bedroom they would each have and other decisions about the move. People told us about this when we visited and confirmed they had been involved in choices about their new house.

People were encouraged to be as independent as possible. Care staff in one house told us how they supported people to be involved in household chores. They told us, "[Name person] likes to take the bins out". Care staff described how they discreetly observed the person when they did this to ensure their safety. Other care staff told us how they included people in day to day routine activities and tasks. In several houses we saw staff supporting people to make drinks and snacks. People were offered choices and enabled to do all parts of the task they could safely accomplish with staff only doing the bits required. For example, one person was making a hot drink. Staff prompted them to choose a cup and put in the tea bag. Staff added the boiling water and the person got the milk from the fridge and removed the top before staff also added this and removed the tea bag. This showed that staff ensured people were fully involved and encouraged to be as independent as possible.

Staff were knowledgeable about people and told us about the things people enjoyed doing, what they liked to eat, what was important to people and their communication needs. Care staff were organised into house teams and told us they invariably worked with the same people. This meant they had had opportunities to get to know people as individuals and what mattered to them. We saw care plans contained detailed information about people's communication methods. Where people were unable to express themselves verbally, information about how they may express themselves in other ways was included. Care staff described how they could identify if people were in pain through behaviours and how another person would take their hand and point to what they wanted. We saw care staff communicating effectively with people demonstrating that they valued people's views and opinions. The service had links with and staff knew how to access advocacy support if this were required.

All records relating to people were kept secure within the agency office with access restricted to only staff who should have need of access. Records kept on computer systems were also secure with passwords to restrict access. This helped ensure people's rights to privacy and confidentiality were maintained.

Good

Is the service responsive?

Our findings

People we spoke with were very satisfied with their care and the way it was planned and delivered. One person said of care staff, "They help me". Another person said "I'm very happy". One relative told us, "The staff are very good, they always keep me informed about any changes and involve me in decisions". Relatives told us they had been included in discussions about how their loved ones care should be provided and that reviews were held to which they were invited.

One care staff member said the "Care plans are good, everything is there that needs to be to provide care". Another care staff member said the "Care plans are really useful". Care plans reflected people's individual needs and were not task focussed, they included guidance for staff as to how people should be supported in various situations. For example, should people have specific medical needs such as epilepsy or diabetes, care plans included information about these. Copies of care plans were seen in people's houses allowing staff to check any information whilst providing care.

People confirmed they had been involved in planning their care and in review meetings of their care plans. One person told us, "We have reviews here at my home". A relative said, "Communication between us all [service, relative and person] is very good and we have reviews together. We had one not long ago". There was a system that care plans could be reviewed and updated as needs changed or on a regular basis. Records were kept of monthly meetings between people and their keyworker.

A record of care provided was kept for each person. Records were kept daily including where necessary, food and fluid intake, medicines, activities, and personal care provided. Daily records showed people occasionally required a change to their routine, perhaps due to ill health. Staff responded to this and ensured care was provided to the person. For example, one person had recently been in hospital. Staff described how the person usually went with them to get all their food shopping or prescriptions. However, at present the person was not well enough to do this so staff were supporting them to make a shopping list which they [staff] then shopped for. We saw that when people required emergency medical treatment this was promptly provided. In one house a person had had an episode of unresponsiveness. Staff had immediately summoned paramedics and provided emergency care as required. This showed staff were able to meet people's usual routines and respond when changes were required.

People and their relatives were confident that care staff or members of the management team took their concerns seriously and took appropriate action in response to any issues raised. A person told us, "I would tell [name care staff member]" in response to the question about what they would do if they were unhappy about something. Information on how to make a complaint was included in information about the service provided to each person. The complaints procedure was in a suitable format describing the steps to take and included pictures and contact numbers of the people to contact. The registered manager was a frequent visitor to the various houses people lived in providing an opportunity for people to discuss any concerns they may have. Staff and people were able to name the provider's area manager who had visited most of the houses. Visits by senior managers provided people and staff with opportunities to raise areas of concern directly with them.

Should complaints be received there was a process in place which would ensure these were recorded, fully investigated and a written response provided to the person who made the complaint.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke positively of the leadership and felt the service was managed well. One person told us the registered manager had visited them and, "talked to me". Other people also confirmed the registered manager had visited them and their responses showed they felt comfortable to discuss concerns with her. One relative told us were aware of how to contact the team leader or registered manager if they needed to do so. Another relative told us "I usually go to the care staff or the team leader but I'm sure I could speak to the manager if I needed to". People, relatives and staff all said they would recommend the service to a relative or friend in need of this type of care.

Although people and relatives were happy with the care provided and felt the service was well led we identified areas where improvements were required as detailed within the safe and effective sections of this report. The provider's quality assurance procedures had failed to identify these issues which related to the management of risk and ensuring legal rights were protected under the Mental Capacity Act 2005.

The provider was using internal quality assurance frameworks to govern the running of the service and were completing internal audits however these had not identified the areas of concern we found. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help identify shortfalls in service provision so the provider can take action to drive improvement and promote better outcomes for people. Regular audits were completed in relation to each aspect of the service such as people's medicine administration records, care plans, staff supervision and training. The registered manager told us that team leaders were required to audit aspects of their service monthly. They were also required to record information about events that had occurred in the service, such as any accidents and incidents which were then reviewed by the registered manager and included within the providers on line quality monitoring systems. They explained this information was also analysed by the provider's quality team to enable them to identify any themes or trends which were then fed back to the registered manager for them to take action. The provider's quality monitoring team also undertook formal audits covering all aspects of the service. We viewed the audits completed which showed that there had been an ongoing improvement in the overall quality of the service as assessed by the provider's quality monitoring team.

The registered manager told us they were supported by the provider's organisational structures. For example, they explained the provider had a dedicated human resources team who could give advice and guidance in all matters relating to managing staff. A training department helped ensure staff received all necessary training and a policies team ensured the services policies and procedures kept up to date with changes in best practice guidance. In January 2017 the service provider had become part of a larger care provider. Whilst most of the records viewed continued to show the original provider name the new provider was in the process of reviewing and updating documentation, policies and procedures.

Feedback on the quality of the service provided was sought from people, relatives and staff on an individual and on-going basis. The registered manager told us they spoke with people and staff to gain their feedback and carried out 'spot checks' on records. They told us some of these visits were planned and some were

'unannounced' and that they spoke with people and observed how staff interacted with people. This enabled them to have oversight of the service and monitor whether or not they were following the provider's policies and procedures and meeting people's needs.

All the staff including the registered manager told us people came first and it was apparent from our conversations with people, their relatives and staff that this philosophy governed the day to day delivery of care. Staff described the services values as being to "Promote choices", "Support people to be happy" and to ensure people were able to live "Their life as they wanted to".

Staff spoke with enthusiasm about their work. One staff member told us they enjoyed their work and said, "This is the first job where I have ever looked forward to actually going to work". Another care staff member commented, "This is the best job I've ever had". A third care staff member who had not previously worked in care told us they were, "Really enjoying their change in career".

There was a clear management structure in place. Staff were aware of the line of accountability and who to contact in the event of any emergency or concerns. Staff felt well supported within their roles and described the management as approachable. Houses had been grouped geographically and had their own, or shared with a nearby house, a team leader. Team leaders also undertook care shifts providing day to day support and care for people.

Care staff were also positive about the team leaders and the registered manager. Staff told us the registered manager was approachable and they felt they could raise concerns directly with her and senior managers if required. Care staff told us about other support and we saw 'out of hours' contact numbers and details of the nearby 'buddy' houses were in place. Another care staff member said of the management team, "There are no problems with them, they listen to us".

There was an open and transparent culture. We spoke with a staff member from the local authority. They told us the management team were responsive and when issues or concerns had been identified they had acted appropriately to investigate and if necessary amend practise. Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. The registered manager was aware of what needed to be reported to the local authority under safeguarding and to CQC as a formal notification. Records showed that notifications about significant events were reported to CQC as required. There was a duty of candour policy in place which required staff to act in an open way if people came to harm. The registered manager was clear about how and when it should be used. Staff were aware of the provider's whistleblowing procedures and told us they would not hesitate to raise any concerns they had about poor or unsafe practice. One staff member told us they, "would speak out", and would be confident the team leader and registered manager would act. They explained if they felt they had not been listened to they would go to the local authority with their concerns. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.