Circle Care And Support

Cambridge Supported Living Services

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

This inspection took place on 16 June 2016 and was unannounced.

Cambridge Supported Living Services is a supported living service that is registered to provide personal care to people living in their own homes. Their office is based on the outskirts of Cambridge city. The service provided included that for people with a learning or physical disability. At the time of our inspection there werefive people who received the regulated activity of personal care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a robust process in place to help ensure that only suitably qualified and staff who were appropriate for their role were offered and accepted for employment.

People's assessed health and care needs were identified and then met at the times they required this support. Staff were trained and deemed competent to provide the care people needed or that they had requested.

Staff had a thorough understanding about how to identify any potential harm and who the most appropriate authorities were to report this to if ever this was required.

Medicines management and administration was undertaken in a safe way. This was by trained staff whose competency to do this safely was regularly assessed.

The registered manager was aware of the process to be followed should any person lack mental capacity and thus have a need to be lawfully deprived of their liberty. They and their staff were knowledgeable about the situations where people required some support with their decision making. The service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) codes of practice.

People were supported by staff who knew each person's individual care and support needs well. People were supported and cared for in a way which respected and encouraged independent living skills. People received care in private that was respectful, dignified and compassionate.

Risk assessments had been implemented and these were regularly reviewed to help ensure that risks to people and the risk they took were minimized as far as reasonably practicable.

People were involved in their care needs assessment. People were provided with a wide range of

opportunities and occasions to help them maintain close links with those people and communities that were important to them.

People's nutritional and health care needs were identified and met in a safe way to maintain their health and wellbeing. People were supported by, and had access to, a range of health care professionals including occupational therapists, GPs and community nurses.

Staff were supported with an effective induction and training programme that helped them develop the care skills they needed. Staff were mentored and supervised in the roles they performed and undertook.

People were provided with information in an appropriate format according to their needs as to how to make and raise any suggestions they may have had to improve their care. Action was taken promptly to resolve any concerns that people raised to their satisfaction.

Audit and quality assurance procedures were in place and these were effective. The provider had processes in place, which had been used, to ensure that the CQC was notified about events that they are required, by law, to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported to be safe. Staff knew how to recognise any signs of harm to people and how to report this appropriately.

Staff were trained to administer people's medicines safely and their competency was regularly assessed.

A sufficient number of staff were in place to meet people's support needs. Staff were only offered employment with the service after the satisfactory completion of essential recruitment checks.

Is the service effective?

Good

The service was effective.

Staff had the right training, knowledge and skills to help them support people in the most effective way.

People were given the necessary support that they needed to help them make decisions about their care.

People were safely supported with their health and nutritional needs by staff who promptly recognised any change in the person's wellbeing.

Is the service caring?

Good

The service was caring.

People's care was provided by staff in privacy, with dignity, respect and compassion.

Staff showed concern for people's wellbeing and they knew how to make a difference to people's lives and make people feel they mattered.

People's care details were kept confidential. People could be as independent as they wanted to be.

Is the service responsive?

Good

The service was responsive.

Staff recognised what people's true potential was and what their strengths were.

People were supported with a wide range of social activities that were based on people's hobbies, interests and pastimes.

Appropriate means were provided so that people had access to the provider's suggestions and complaints process.

Is the service well-led?

Good

The service was well-led.

Staff were supported to embrace an open and honest culture and transparency in everything they did.

Quality assurance and audits were in place and these were effective in identifying and driving improvements to the quality of service provided.

Staff were supported in their role and rewarded for good practice and long service. People benefitted from the involvement they had in developing the service they received.

Cambridge Supported Living Services

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 16 June 2016 and was unannounced. The inspection was completed by one inspector and an expert by experience. Their area of expertise was caring for people who have a physical or sensory impairment.

We looked at the information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with one person. We also spoke with three relatives by telephone this was because not everyone who used the service was able to speak with us. We observed the care and support staff provided to people to assist us in understanding the quality of care that people received

We also spoke with the registered manager, the locality business manager, one deputy location manager and three support staff.

We looked at three people's care records, managers' and staff meeting minutes. We looked at medicine administration training records and records in relation to the management of the service such as checks regarding people's home's environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaint procedures, quality assurance and audit records.

Good

Is the service safe?

Our findings

Procedures were in place to help ensure that people were cared for in a safe way. These procedures included the training of staff and the development of their skills in safeguarding people from the risk of any harm. One member of staff told us, "People who can't speak tell us in their own way if they are not their usual selves or if they are anxious or worried about something. I would know straight away if there had been anything untoward happening." One person said, "I feel safe. I see the same and regular staff. I would report to [registered manager] if I was worried about anything." All staff were aware of the various types of potential harm and those organisations such as the local safeguarding authority or the police that they could if required, report their concerns to. Another staff member told us, "I would inform the [registered] manager straight away if I ever had concerns. I have recently done this and [action was taken] straight away. The person is now safe."

People and their relatives or representatives were supported to access information about being safe when the person started to use the service. In addition, people with other communication skills were provided with systems which enabled them to report their concerns if ever this should occur. People were given information about keeping safe in a format that met their needs. For example with sign language, picture cards, objects of reference and the person's body language. Clear and current guidance was in place to guide staff on how to support people safely such as helping people in a way the person was comfortable with. Staff supported people to feel safe using techniques that kept the person calm such as not touching the person's medicines. This showed us that the safety of people was given the relevant consideration it deserved to help prevent any risk of people experiencing any potential harm.

All relatives told us that they felt their family members were safe with the staff who provided a consistently safe standard of care. One relative said, "My [family members] are very safe in [their home] and supervised at all times." And, "The staff encourage them [family member] to be independent as possible ensuring that their safety is maintained at all times as individuals."

We found that there was a process in place that identified, managed and reviewed the risks to people's safety and well-being. This process covered subjects such as people's risk when out in the community, taking prescribed medicines, situations which could cause anxiety and people's financial arrangements. Health and safety checks were undertaken to help ensure that people's homes were a safe place for people to live and staff to work in such as ensuring people's furniture and items of interest were kept tidy to avoid any potential hazards. This showed us that the registered manager and staff considered and acted upon possible risks which may impact on people's safety.

Relatives told us and staff confirmed that care visits were on time and for the specified period. One relative told us, "The care staff never rush." The registered manager showed us how they planned staff rotas and the availability of staff who were qualified to meet people's needs. We found that there was sufficient numbers of staff to meet people's needs and this was confirmed by staff and relatives.. One deputy location manager told us, "If ever there are staff who ring in sick or they are off for other reasons we cover this with existing staff. We also cover some shifts ourselves." The registered manager confirmed that they only used regular

bank staff who knew people well and only in situations where this was safe.

One person told us, "They [staff] do turn up on time and help me do the things I like to do. They don't rush me. If I want my care at a different time they do try to help. They do stay until all my care is done." Staff told us that they had the necessary time that they needed to meet people's care and social support needs. We observed where people had been out on their planned activities and that the required numbers of staff were in place to support each person with their needs.

Systems were in place to monitor and record any incidents or potential near misses. This was for subjects such as but not limited to missed signatures on people's medicines administration records (MAR) as well as any potential neglect. The registered manager ensured that any situation where this had occurred was acted upon immediately with a staff supervision and any appropriate action to ensure that medicines administration was safe. One person told us, "They [staff] get my medicines out and make sure I take them." We saw from people's MARs that these had been accurately completed in accordance with the provider's procedures. Medicines were stored safely in people's homes and disposed of in a safe way.

Staff's competency to administer people's medicines was regularly assessed after they had been trained. This was to help ensure that staff maintained a good understanding of safe medicines administration. We found that the responsibility for medicines administration was clearly identified. For example, where the person independently administered their own medicines this was recorded in their support plan. One person had asked for a two week MAR and the staff had provided this. This was to help the person know exactly when and how often they had taken their medicines. At a review of the person's care needs the person had commented how much better this was with the new form.

One care staff told us, "I had to complete my induction book and then I was trained in medicines administration. Once I had successfully completed my observed practice I was then signed off to administer people their prescribed medicines." Training records confirmed to us that staff who administered medicines were up to date with their training and any refreshers for this. The registered manager showed us how they undertook regular monitoring of staff to ensure safe medicines administration practice was adhered to as well as informing staff when their training for this was due. People could be assured that their medicines were administered and managed safely. We found that people's medicines were managed and administered in a safe way. Examples included the checking of medicines expiry date as well as audits to ensure that safe standards of medicines administration were adhered to.

Good

Is the service effective?

Our findings

Prior to using the service people's care and support needs were assessed and matched against staff with relevant experience and training. On-going changes were made where staff had a particular affinity with the person such as a shared interest such as shopping, music or sensory environments such as a garden centre. This was to help ensure that the staff with the right skills were available to meet people's needs effectively. We observed how people were supported by staff who knew each person they cared for well. All relatives told us that one aspect that meant a lot was having consistent and regular care staff and that in the majority of situations this was respected. One person said, "I do get the same ones [staff] because I need their reassurance."

We also saw how staff responded to people's assessed preferences and choices in a way that the person wanted. This was through a combination of body and sign language, pictures and objects of reference with which the person could point or show to staff. For example a tea bag or tea cup that the person wanted their favourite drink. One person told us, "They [staff] are good [skilled] looking after me as I can be fussy. They know when I am in a good mood as well as if I am unhappy." One relative said, "The staff are well trained to cope with my [family members] differing temperament when [with other people]."

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The registered manager demonstrated to us the systems that were in place to support staff in their role. For example, following staff's initial induction they were supported with a programme of shadow shifts [working with a more experienced member of staff] and training until they were confident to do their job. One member of staff told us, "My induction lasted about six months until I had completed my probation before I was allowed to work more independently. I did quite a few shadow shifts with several different people and this helped me get to know the person as well as giving me a wide range of experience. I learn something different every day even if it is only a small matter." Another care staff told us, "If I ask for, or my one to one (supervision) identifies this, I get the training I need and my competence on this is then assessed either by observed practice or through a conversation at my one to one."

The registered manager regularly sought and was provided with sector specific guidance such as people with a learning disability and kept up-to-date with this. This was from organisations including those associated with people who had autism, or mental health conditions. We found and staff confirmed that there was a process in place that helped ensure staff's planned training and supervision was completed. This included staff enrolling in the Care Certificate. (a nationally recognised standard of care training). All staff told us that they had received regular supervision and training. and were supported by the registered manager and the deputy location managers. As well as the provider's mandatory training staff had access to and were supported by an in-house trainer who provided moving and handling awareness, medicines administration, infection control and prevention and food hygiene training.

Staff were also provided with more specialised training on subjects such as British sign language, autism, epilepsy and other subject specific training based upon each person's health and support needs. This was through a combination of e-learning, guidance documents and external health care professionals. Staff were knowledgeable and informed about people's diabetes and the signs and symptoms to be aware of if a

person ever appeared, or was, unwell.

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. People can only be deprived of their liberty to receive care and when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. We checked whether the service was working within the principles of the MCA.

We found that the registered manager and all staff had an embedded understanding of the MCA and Deprivation of Liberty Safeguards (DoLS) codes of practice. For example, assuming in the first instance that people could make their own choices. One relative said, "They [staff] let my [family member] decide what they want to do, wear and spend their time. It's up to my [family member]. They [staff] give choices such as when to take medication." We observed that staff always involved people in conversations. This was to maximise people's ability to make a decision. The registered manager showed us how they had, as a result of people lacking capacity, contacted the social worker, health care practitioners and the local authority. This was to apply to lawfully deprive a person of their liberty and to care for them in the person's best interests. Any restrictions in place such as staff being with the person when they went into the community were implemented in the least restrictive way. For example, by supporting the person to do this as independently as possible.

A member of staff told us that the MCA was about, "Always assuming people had capacity and respecting their unwise decisions." The staff member went on to give us an example of an unwise decision, "When a person decides to not take their prescribed medication and that the person could weigh up (understand) the consequences of their action." Another staff member said, "I always offer a choice such as shower gel, soap, options of clothes to wear and foods to eat by holding the container the food came in which the person could then choose. Just because the person can't speak doesn't mean that they can't make informed decisions with a little support."

Care plans recorded, and care staff told us, the appropriate dietary arrangements that were in place such as those for a low fat content diet. Care plans recorded in detail how people needed to be supported to eat and drink sufficient quantities. For example, giving people encouragement to eat an appropriate portion and of healthy food options wherever possible and one person told us, "I like my food and I do my shopping with staff. They help me budget and choose so that I don't just buy [unhealthy food]." One relative said, "[Family member] has [certain] needs and the staff ensure they meet these." We saw and people told us that they were kept hydrated and had access to fruit and snacks throughout the day. Where people went out into the community staff encouraged people to have drinks that were low fat where the person's diet required this.

Care staff told us, and we found, that they supported people to access health care professionals including a GP, dietician occupational therapist and community nurses. One person told us, "If I need a GP I am happy for staff to call one. I make most of my own appointments anyway." We saw that various referrals had been made to health care professionals including but not limited to a GP and occupational therapists. This was for changes to the equipment people had been provided with to reduce the likelihood of a fall as well as helping to improve people's independence. Support and strategies were put in pace for the person to get the best out of their visit to health care professionals. For example, by doing this in stages and at a pace the person benefitted the most from. This showed us that people's healthcare needs were responded to.

Good

Is the service caring?

Our findings

People we spoke with and whose care we observed communicated to us that staff provided care with consideration of the person's needs. Staff cared for and supported people with compassion and understanding. People were made to feel they mattered. This was by staff who respected people's abilities and the positive aspects of their lives. For example, going out into the community for banking, shopping and being as independent as practicable as well as making sure people received personal care in a sensitive manner. One person said, "Staff are nice and they do a bit of everything (care and support) with me. They do it respectfully." Relatives spoke positively about how caring the staff were with one saying, "I am treated at all times with respect from the care staff and I have observed [frequently when visiting their family member] that my [family members] are spoken to with respect." Staff used a light hearted approach to people's care but they were also mindful of people's understanding of when it was appropriate to have a laugh or share a joke.

Staff gave us examples of how they communicated with each person they cared for. This was through a variety of assistive technologies using signs and symbols to help people to communicate. These included picture cards, objects of reference such items of food, sign and body language as well as people's vocalisations. This helped promote respectful and compassionate care. Examples we saw being used included staff's awareness of how people could tell staff that they were in pain such as by being withdrawn or with facial expressions. One staff member told us, "I know when [person] is happy and I would certainly know when they weren't. It is important that we know the positive aspects of people's care such as keeping them as anxiety free and therefore as happy as possible." Another staff member said, "Each person is an individual and we have to respect their wishes even if this sometimes means the length of their care and support was impacting on the time we had to spend with them." The same staff member went on to say, "We have distraction techniques in place that maximises people's time with their care needs as well as the person's right to independence."

We saw from records viewed that strategies and people's coping mechanisms were used to bring out the best in each person. For example, by allowing the person time, with support, to undertake the aspects of their lives that were important to them such as taking their prescribed medicines regularly. One relative told us how staff helped their family member to try to maintain a healthy lifestyle but in a caring way by respecting the person's choices. Another relative told us that they were very happy with [family members] support and that it was a very hard decision for them to move into supported living. Knowing that they were being well cared for at all times made it easier for them to cope.

We observed and found that staff respected people's privacy and dignity by using the most appropriate means. For example, letting people wash as much of themselves as practicable, giving them privacy to do this. Staff explained each stage of what they were doing and what the person was able to do. One deputy location manager told us, "There are people who like to leave the bathroom door open so if any visitors are due we make sure the door is closed or the visitor has to wait downstairs until it is okay that the person is happy for them to enter their home." A relative told us, "[Family member] only likes the girls [female staff] and this is what they are supported with."

Where people had a particular preference for the way staff entered the person's home this was respected. People's care plans clearly identified the guidance on how each individual person liked staff to introduce their arrival. This was also for those people who used non-verbal communication skills to make the person aware of staff's presence. This was to minimise the impact on the person as well as reducing the potential for any anxieties. Examples we found and observed included the use of an assertive firm voice. This was a way the person responded positively to and that staff had clear boundaries of when this was appropriate and caring.

We saw people's care plans contained the level of detail that was required to meet the person's support needs. One care staff said, "I love my job and caring for people living with a learning disability. It means so much to me to see the person smile. Even if I have made the smallest improvement [to the person's care] or the day has been challenging [very busy] for me I still go home knowing I have made a difference." Staff told us that this had been for those occasions when a person demonstrated their happiness with vocalisations, laughing or just being themselves.

Staff's conversations with us clearly showed us how passionate they were about making a difference to people's lives with as much meaningful interaction as possible. This was because staff were able to tell us about and describe the care needs of each person that they supported such as those with quite complex health support and care needs. One relative told us, "The staff are very caring at all times." Staff spoke to us about what people could do and of their potential such as carefully increasing people's exposure to situations in stages until the person was able to achieve an aspiration such as living completely independently.

People were provided with information and organisations which could advocate and speak up for them. Where people had the potential or were being lawfully deprived of their liberty, formal advocacy was encouraged such as with an Independent Mental Capacity Advocate. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes that they could not always make for themselves.

People were involved in their care planning in various ways such as through a one to one discussion with the person's preferred means of communication. Where required, people had formal and informal advocates as well as relatives to help inform their care planning. This was when the person started to use, and also during their use of, the service. Examples of this included staff's day to day conversations and communications with people and their relatives and family members. This also included more formal reviews of the person's care needs. On these occasions staff took the opportunity to give people the explanations they needed in a format that enabled the person to be involved as much as possible. For example, with sign language, picture cards or sounds that staff knew what the person was telling them.

One person told us, "I can go to see my [friends] when I want and they can come to see me." Staff told us that if a person wanted to be with their friend and not meet staff then this was respected. The staff told us, "I know when [person] is happy to be cared for and when they have a [more important person] to see. We saw and relatives told us that as far as possible people were supported in a way which meant the risk of social isolation was minimised. For example, with visits to or by relatives and visits to day centres.

Good

Is the service responsive?

Our findings

People's care needs were assessed using a combination of methods. These included the local authority's and provider's assessment process as well as the person's input. This was for their individual preferences such as favourite film, having their hair done and only having female care staff. This was also to identify those aspects of people's lives that were important to the person. One staff member told us, "It's knowing the verbal reassurance people need and repeating questions and giving the person time to understand their answers. For example, by giving simple and short instructions and not more than one task at a time." Methods used to help identify what worked best for the person included the use of people's various communication skills to enable them to take part in the assessment process. These included sign language and objects of reference people could point or indicate with other means about what the person was 'saying'. This was to help ensure people's preferences were clearly implemented in a way the person wanted them to be.

People were supported to meet with friends at the time of day they preferred as well as going out to take part in social activities such as, but not limited, to cooking or baking, going swimming, shopping, to the bank or going out in their own, or public, transport. One person told us, "I like going to my day centre and doing art or accessing the internet." We found that the provider had accurately assessed people's needs. One deputy location manager told us that people's care plans were always kept under review. Where a person's care and support needs changed such as with the provision of equipment to promote independence and alternative medicines in a liquid format, this was acted upon promptly. This was to help people enjoy and get as much out of their lives as practicable and showed us that the service considered each person's individual care.

Strategies were in place to ensure that people were not exposed to undue risk such with the management of their finances and general health and well-being. These strategies included counting down from five to one to help people to take their medicines as prescribed. Staff used mirroring techniques such as clapping or singing with the person to help identify what the person was telling them. Staff told us that they included the person as much as possible using their preferred means of communication such as sign language. This helped staff identify what worked well for each person as well as being aware of any potential triggers for people's behaviours which could challenge others and the avoidance of these such as by recognising if a person was becoming louder in their vocalisations.

People received care from staff who really knew what was important to the person. One deputy location manager had identified ways to improve people's reading skills. This was through a book club. They told us that if people were to be able to go to a library that met their needs then the best way to do this was to create one. They had researched this and done this in their own time. As a result of their involvement people could now access books in audio and film versions and in a format that involved and enriched the person's life the most. People who previously would not have been able 'to read' could now do this and the book club was growing with more people using it as they had identified the benefits to their lives. For example, with discussions about the book. People could say that they didn't like a book or that they had loved it. It was their individual choice.

Staff also held residents' meetings with people where they could discuss holidays as well as introducing information in stages and at a pace the person was comfortable with. One deputy location manager described how they had gradually helped one person understand what abuse could mean such as if ever the person was ever referred to by an inappropriate name. This showed us that each person and their individual needs were considered and acted upon.

One relative told us, "They [staff] support [family member] to do the things [family member] likes. People were supported to take part in past times that any person was able to do such as going out in their transport or out for a meal. Another relative told us, "My [family member] is always encouraged to have hobbies but sometimes [family member] is not interested in anything." This was because the person could choose how independent they wanted to be.

Staff supported people with their preferred hobbies and interests such as playing draughts, doing sketching, knitting as well as trips to country fairs. We found that staffing to support people was based upon a consistent approach with the same regular staff supporting people wherever this was possible. This helped ensure that people got the best out of the care they received.

The provider had a complaints process and procedures in place. This was in the form of a service user guide as well as easy read pictures. We saw that the provider had followed its procedures and responded to people in their preferred format such as by e-mail. The provider supported people with their complaint to reach a solution that the person was satisfied with. Only when people were completely happy with their complaint resolution was the complaint closed. We saw that various means were provided to support people to comment on their care. These included communication passports and assistive technology. This included details on how to contact the registered manager as well as other organisations such as the Local Government Ombudsman. One relative told us, "I have never needed to make a complaint but I know what to do."

Good

Is the service well-led?

Our findings

People were supported to be involved in developing and improving the service as much as practicable. This was through e-mails, face to face meetings as well as support from health care professionals. We saw that people's views about their care had been sought. Where people wanted their relatives involved this was clearly identified and people's right to privacy was respected. We found that people benefitted from their involvement by being listened to and their wishes acted upon. This included the person's preferred means of communication and the skills people had in the use of their objects of reference, picture cards or sign language. This included staff's knowledge about what exactly it was that the person was communicating.

People's and relatives' views were sought using telephone calls and face to face meetings to review the person's care. When necessary, reasonable adjustments were implemented with equipment such as keyless access to people's homes. This was to improve people's access to the community. The registered manager used an electronic records system to help them identify any trends in people's behaviours which could challenge. If any concerns were identified such as an increase in people's anxieties or unwise decisions about taking medicines with drinks that were unsuitable to take at the same time then this was acted upon. Ways in which this was achieved was by meeting with the person and removing situations which could tempt them or cause potential harm such as not having alcohol in their home. This showed us that the registered manager took proactive steps in improving the quality of the service.

The provider had undertaken a quality assurance survey of the service for 2015. This had shown improvements in all areas covered from the previous survey in 2014. Comments from people included, "Staff do a very good job and support me really well" and "could do with a little more rota communication - i.e. not leaving it until Monday to let me know who I've got". Improvements that had been made included the provision and use of pictorial staff rotas. This was so that people would know the staff who were providing their care. One person told us, "A perfect day for me is going out shopping with the girls [staff] and I know exactly which one's [staff] this is which I like."

Our observations showed us that the registered manager and staff were well informed and understanding of people's communications. This was because of the positive way in which people responded with laughter, happiness and general wellbeing. One person told us, "They [registered manager] come to see me and I know their name. If there is ever anything I want to change they listen." The person told us that this was because when they asked for something it was provided. For example, support to see a dentist or being able to sleep where they felt most comfortable.

Staff were supported to embrace an open and honest culture and transparency in everything they did. One relative said, "I have never needed to complain but I would if I had to without reservation." They told us that this was because the registered manager was an approachable person. Staff embraced the provider's values of enhancing people's life chances and celebrating difference. Staff were asked for their views at staff meetings as well as when being able to comment on any relevant issues when they visited the service's office. This gave staff the opportunity to comment on what worked well and where changes were needed such as what each person's achievements had been since the previous meeting. The registered manager

ensured that all staff attended or were informed of the outcomes from meetings. Subjects covered in meetings ranged from general standards of care, where more accurate recording of medicines was required and staff to not use their mobile phones to call the office in people's homes. One member of care staff told us, "The meetings are good as we can catch up on wider issues as well as the people we care for."

Other ways improvements were made was in access to swimming and bathing facilities that people attended which were warmer and better suited to people's needs.

The registered manager told us that the biggest challenge was having and maintaining a staff team that was skilled in meeting people's care needs. They said, "Many of the people we care for are not just unique as an individual but also where people have multiple, combined and complex care needs. I need to make sure I get the right staff but not just any staff. It is their attitude above everything that matters. Everything else we can train them for." They added that as a result of having the right staff, the benefits to people were, "Changing people's lives for the better." Relatives we spoke with confirmed to us that this was the case. They went on to tell us that the service learned from incidents that had occurred and that actions taken were monitored. This was to help ensure that any improvements that were put in place were effective.

All staff we spoke with confirmed that the support they received from the registered manager enabled them to do their jobs to the best of their ability. For example, with a frequency of supervision that was based on people's and staff's needs. Support to the registered manager was also provided by a representative of the provider. This was for wider information such as new developments in technology and the recognition of good practice in the learning disability care sector. Less formal methods of support were also available for staff. One member of care staff told us, "They [registered and deputy location managers] are only a mobile phone call away. If I am not sure of something I can call [the office] as well as using the out of hours contact centre. It's nice to have the reassurance that they are there for you if you need them." The locality business manager told us that they visited the service regularly and offered coaching and support to the registered manager when required.

Information from people's care records was used to identify where people had achieved something for the first time such as going swimming or where people had been much less anxious because of the care and support that was in place. The registered manager told us, "I see people [using the service] quite a lot because I work some shifts. This was to observe staff's care practice as well as assessing if we are meeting the person's needs in the best possible way." This was also to help ensure that the care staff were working to the right standards as well as exhibiting the provider's values. One member of care staff told us, "We have to have an observed assessment of the way we support people. You never know when you are going to be checked. If there is anything that we need to improve upon we are given feedback in a constructive way."

The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the registered manager had notified us about these events where required. The registered manager had access to various means to identify good and best practice. This was through a range of forums including provider's meetings where information for national organisations such as those associated with people with a learning disability and other health conditions which people had.

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said, "Most people I care for are vulnerable and if ever I had any concerns whatsoever I would report these to [registered manager] and that they would support me." One person told us, "I know all the staff in the office. If I was worried about anything I would just ring them. I am happy so I don't need to." And, "I can't think of anything that I would like changing or improving. It's good as

it is."