City Care Partnership Limited

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Inspection report

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Date of inspection visit:
04 October 2016

Date of publication:
30 November 2016

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

City Care Partnership provides domiciliary care to young people over the age of 16 and adults with a learning disability and autism.

This was an announced inspection on the 04 October 2016. Two days prior to the inspection, we contacted the provider and told them of our plans to carry out a comprehensive inspection of the service. This was because we needed to be sure that someone would at the office.

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

Policies and procedures were in place to safeguard people from abuse and staff had received training in safeguarding adults. Staff were able to tell us how to identify and respond to allegations of abuse. They were also aware of their responsibility to 'whistle blow' on colleagues who they thought might be delivering poor practice to people.

We found recruitment procedures were robust, people and family members were involved in the selection process which meant new staff should be suitable to look after the people who used the service.

People were encouraged to self-medicate if they could. Staff were trained in medicines administration and had policies and procedures to follow good practice. The administration of medicines were safe.

Risk assessments did not prevent people from enjoying their lives but helped them keep safe.

Staff were trained in techniques to de-escalate any behaviours that challenged to help keep people who used the service safe.

People who used the service told us they liked where they lived and were involved in running the home. This included having their say in meetings and also keeping the home clean, shopping and cooking.

People were supported to take a nutritious diet and sufficient fluids to remain healthy.

New staff were inducted to the service and enrolled on the care certificate. Staff who had completed this induction or worked at another service had their abilities assessed and enrolled on any training to support them to look after the people who used the service. Training was extensive, tailored to staff and people who used the services needs and relevant to the role they performed. Supervision and appraisal was ongoing and tied to the services quality assurance framework to provide a better service for people.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards.

We observed that staff knew the people they looked after well and had a good rapport with them.

The service matched people who used the service with a staff member who had similar interests which enabled them to do what they liked together.

We saw that the religious needs of people who used the service were recorded and people had the opportunity to follow their faith if they wished.

People were able and encouraged to attend activities in a group or as individuals. We saw the service took care in helping people with Autism or learning disability to attend new activities in a planned way to ensure all went well. There were many records of what people enjoyed. People were given opportunities to attend work or college if they wished.

Staff were able with training and specialised equipment to support people who had problems with verbal communication.

People who used the service told us they felt able to complain. The complaints procedure was available in an easy read format and there were photographs and contact details of managers, which gave people a clear message who they could complain to.

The assessment process helped ensure people who used the service were aware of what was happening and they were given sufficient time to become used to moving into supported living.

Plans of care were extensive, holistic and reviewed regularly to keep their health and social care needs up to date.

There were systems in place to monitor the quality of service provision. The service had a planned development plan which laid out how they intended to improve the service.

People who used the service and staff told us managers were approachable and supportive.

People who used the service, staff and relatives were able to attend meetings to help decide how the service was run.

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.

Medicines were administered safely by staff who had been trained to do so.

Staff members knew their responsibilities in relation to safeguarding. They were able to tell us how they would respond if they had any concerns for the safety of the person who used the service.

Staff were recruited safely using robust procedures.

Is the service effective?

Good

The service was effective.

Staff received the induction, training and support they needed to carry out their roles effectively.

People who used the service were supported to take a healthy diet. Staff had received training in nutrition and gave support and advice to people who used the service.

People's rights and choices were respected. Staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

We observed the good rapport between staff and people who used the service who came to see us on the day of the inspection.

Personal records were stored securely to keep them confidential.

People who used the service told us staff were caring and kind.

Is the service responsive?

Good

The service was responsive.

People who used the service were matched with staff who had similar interests to help support them to do the activities they wished. This ensured people led the lifestyles they wanted to. Staff were trained in a person's communication and behavioural needs need's to ensure they could help them with access to the community.

People who used the service said they felt able to raise any concerns with their support workers or the registered manager. Documentation was provided in an easy read format to ensure people

Plans of care contained considerable details of a person's health and social care needs for staff to provide suitable care.

Is the service well-led?

Good

The service was well led.

There were sufficient audits to ensure the quality of service provision was maintained.

Staff told us managers were supportive and they all supported each other to work as a team.

There were robust systems in place to asses, monitor and review the quality of the service. People who used the service felt listened to and were involved in developing the service.

City Care Partnership Limited

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 checked 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 04 October 2016 and was announced.

The inspection team consisted of one adult social care inspector.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We received this prior to our inspection and used the information to help with planning.

We spoke with the registered manager, three members of the care team, three further members of staff who explained their roles and specialist support they provided and three people who used the service.

We looked at the care records for three people who used the service and three medicines records. We also looked at four staff personnel files and a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us, "I feel safe where I live. I can chill in my room if I need privacy", "I feel safe where I live – nobody bothers me" and "I feel safe where I am living. I live in a house with two others. I get on with them although we have different interests."

We saw from the training matrix and staff files that staff had received safeguarding training. Staff had policies and procedures to report safeguarding issues and also used the local social services department's adult abuse procedures to follow a local initiative. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told staff about the types of abuse, how to report abuse and what to do to keep people safe. The service also provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith. There had not been any safeguarding incidents at the service. Staff members told us, "I would not hesitate to use the whistle blowing policy if I saw any abuse", "I would definitely be prepared to use the whistle blowing policy if I saw poor practice" and "I would be prepared to use the whistle blowing policy to report or deal with any poor practice." There were systems in place to help protect people from possible abuse.

People who used the service had an assessment about their abilities to handle their finances. Following the assessment support was provided to those people who required assistance with paying bills, shopping and day to day expenditure. Where possible people were assisted towards managing their own finances. Where this was not possible we saw there were checks and measures to prevent possible financial abuse.

We looked at four staff records and found recruitment was robust. The staff files contained a criminal records check called a Disclosure and Barring Service check (DBS). This check also examined if prospective staff had at any time been regarded as unsuitable to work with vulnerable adults. The files also contained two written references, an application form (where any gaps in employment could be investigated) and proof of address and identity. The checks should ensure staff were safe to work with vulnerable people.

People who used the service were involved in choosing new staff at interview. Family members were also asked to send in a list of questions they wanted staff to ask prospective employees. This helped people who used the service pick staff they thought they could get along with and enjoy activities together.

This was a supported living service and people lived in their own homes. The registered manager arranged for people who used the service who were able and wanted to come and talk to us at the office. Each person was supported by their own member of staff. For the majority of people support was provided on a one to one basis supported by a central management team with specialist knowledge. The central management team consisted of staff who had qualifications or experience in subjects such as clinical psychology, speech and language therapy, project management, training and specific topics like Autism. This meant people were supported by sufficient numbers of well trained staff.

People who used the service said, "They give me my medicines on time." and "I remind staff when I need to

take my medicines and they give them to me." We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. All staff who supported people to take their medicines had been trained to do so. We looked at three medicines records (MAR) and found they had been completed accurately. There were no unexplained gaps or omissions. The medicines records were checked by managers to ensure there were no errors. In the plans of care we saw there were assessments for people's capabilities to administer their own medicines. If it was possible people were able to self-administer medicines although the plans we looked at and people we talked with needed some form of support, for example prompting or full assistance.

In the plans of care there was a description of each medicine and what support a person required. There was also a British National Formulary for staff to refer to for any further advice on medicines. There was a protocol for any 'as required' medicines which told staff when to give the medication, what it was for and how often it could be given.

People lived in their own homes but were supported by staff to order and store medicines safely. Managers checked staff competencies to safely administer medicines. Part of the health charter for adult social care (this charter committed the service to attain certain standards for people with learning disabilities) the service had committed themselves to look at how people could be supported to take their own medicines safely.

We saw in the plans of care that people had personalised risk assessments for any behaviours that may challenge staff, risks in the community or within the home, using transport, possible harm to themselves or damage to their property. There was clear guidance for staff to spot the known triggers or signs for when the person was becoming agitated and how they could divert the person to de-escalate the situation. All staff who looked after the person had to sign the document to say they had read and understood it to be able to react as quickly as possible to any risks. The risk assessments were comprehensive but did not restrict what the person did. They allowed people to live an active life in the safest way.

People were supported by staff to help keep their homes clean and tidy. There were infection control policies and procedures for staff to follow good practice and staff were trained in infection control topics. Staff had personal protective equipment, for example gloves and aprons if they required them for the prevention of cross infection. There was a regular audit of people's homes which also checked the systems for infection control.

Part of the activities people took part in included learning life skills and how to aim for independent living. This included keeping their houses clean and tidy with staff support. People we talked to said they were supported to keep their houses clean and were supported to do their laundry.

Each person has a personal emergency evacuation plan (PEEP). This informed staff and other organisations such as the fire brigade how to safely evacuate a person, including any possible behaviours that may pose a risk and what level of understanding they may have in the event of an emergency. There was also a business continuity and contingency plan which covered breakdown in the service and how they would respond to keep people safe. This included gas and electricity failure, staffing problems in bad weather, outbreaks of illness, computer failure and loss of water. There was a plan to rehouse people if their house was severely damaged.

People who used the service also had a 'hospital passport' type document. This gave other organisations sufficient details to care for the person, for example if an urgent admission to hospital was required. This

was particularly important because some of the people who used this service may not fully understand what was happening to them or react in an unexpected way.

Some people who used the service had behaviours that may challenge. We saw that staff were trained in safe techniques to de-escalate situations and had support from specialists such as a clinical psychologist to support them or look at new ways to help a person. A lot of emphasis was put on spotting early signs of possible incidents and how they could try to help the person remain calm. In the plans of care we saw how the service taught staff what to look for and gave different stages of what they could expect if their intervention did not work and further instructions to follow if behaviours worsened. Any incidents were recorded and analysed to help prevention of further incidents. We saw that the plans helped protect the person from harming themselves, others or property.

Good

Is the service effective?

Our findings

People who used the service said, "I like where I live. I have made my room my own, nice pictures and a big television", "I like living where I do and the help that I get. I live on my own and prefer that to sharing" and "I am happy where I am living." We did not visit people's houses because people with autism sometimes do not react well to new situations or personnel. The people we spoke with were all happy to come to the office to see us. However, we were told that there was a system to repair any faults and management conducted regular audits at the houses to check everything was in good order.

The service worked out of an office near the centre of Cheadle. There were rooms for training or private meetings. There was sufficient equipment to run a modern office with email access, telephones and other suitable equipment. The building was maintained by the services own maintenance department. Fire equipment was maintained and drills were undertaken to keep staff safe in the event of an emergency.

People who used the service said, "I help cook at the home. We have a rota and use a recipe book. Staff support me with my cooking. We go shopping for food. We sometimes eat out", "I go out and shop for my food. I help cook with staff support" and "I help with the cooking and keep the house clean." Part of people's activity programs was to prepare for and cook a meal dependent upon their abilities. We saw that all activities were planned for the week and where it was a part of their program the results were recorded. This enabled staff to monitor their progress.

People were encouraged to plan their menus and help with shopping for food. Staff supported people to look at healthy options. We saw that where people had religious or ethnic needs their food was sourced and cooked appropriately. A person's dietary needs were recorded in the plans of care as well as any support the person required to eat a meal. Where people had communication difficulties pictures were used to help a person decide what food they wanted to buy or eat. We saw good guidelines for one person who may overeat or rush a meal. The service also employed a speech and language therapist who could advise staff on best practice issues around eating, use of specialist equipment and nutritional advice. This also included any choking risks a person may have. People who used the service were also reminded about safe hygiene around preparing food such as washing hands and storage of food.

Staff were trained in safe food hygiene and nutrition to help them advise and support people who used the service take a well-balanced diet. The service were also assessing their systems to sign up to the health charter for adult social care. This is a pledge by the service to improve the lives of people with a learning disability and includes good nutrition to help people remain well.

All new starters were required to complete a thorough induction which was carried out over a period of 13 weeks. This consisted of the completion of an initial induction checklist then staff completed the care certificate, which is considered to be best practice for people new to the care industry. If an individual had already completed the care certificate in their previous job or had worked in the care sector previously they had to complete a self-assessment. This ascertained what knowledge and experience they already had and highlighted any areas where additional training was needed. The individual would then be required to

complete this training as part of their induction and be able to pass their probation period. Staff had to read all the key policies and procedures to ensure they were aware of good practice issues, learn how to complete all the necessary documents, for example incident recording, care plans and daily records.

Staff were also matched to a person who used the service. Part of the induction process was to take new staff along to meet a person who used the service who had similar interests, were shown around the facilities and shadowed until they felt competent to care for the person and management were confident in their abilities.

Staff told us, "I have completed enough training. We get plenty of training opportunities", "There is enough training to do the job" and "I have done enough training to do my job. It is ongoing all the time." We looked at the training matrix and talked to staff about their training. Training was extensive and covered all mandatory topics such as health and safety, safeguarding, behaviours that challenge, medicines administration, risk management, fire safety, moving and handling, first aid, infection control, mental capacity, the deprivation of liberty safeguards and food safety. Senior staff completed more advanced courses in some of these subjects.

Training was also undertaken for specific subjects, for example Autism, alternative skills to aid people who may not understand verbal communication, maintaining and promoting health, person centred thinking and planning, epilepsy, swallowing difficulties, team leadership and activities. Training was centred around the care people needed.

Staff were encouraged to gain further qualifications such as a diploma in health and social care. Managers were supported to take qualifications relevant to their roles which included training for supervision and appraisal, in depth safeguarding adults and team leader apprenticeship. Some staff had undertaken further training for them to be able to teach support staff. One staff member said, "I completed NVQ level 4 and the registered manager's award. I am now completing positive behaviour support level 4 diploma training. I am a physical intervention trainer which means I update my own training every six months to keep up to date my competency as a trainer is checked every three years."

The Autism lead and project manager told us. "All of our training caters for different learning styles and uses a number of different methods including; traditional training, workbooks, online courses, seminars, observations and reflective logs. This ensures that new workers are offered training and support which fulfils their needs and has a positive impact for the people we support, by putting learning into practice, and reflecting on how this could be improved. Training is checked and logged on the training matrix, which is monitored by our Training Administration Assistant. This records when people have attended training and highlights when they need to receive refresher training.

Staff told us, "I get supervision around every six weeks but you can speak to the manager if you have any issues in between. We reflect on what I say and it helps with career progression", "We get supervision and job consultations or appraisals every year. We get supported" and "We have supervision every six to eight weeks and you can ask for more supervision if you like. It is a two way process and you can ask for your views to be heard." Staff were able to bring up their ideas and needs at supervision and appraisal which made them feel valued.

The service were using an appraisal that took account of what their peers thought of them as well as management. They also gave feedback on management performance. This system was designed around staff's personal development and looked closely at how training had an impact on improving the lives of people who used the service. The results were audited by the project manager who said, "We mainly focus

on professional development. We look at how this impacts on people who use the service, for example promoting dignity. Staff don't just attend a course. They have to show how it has an impact on people who use the service. It's not just about ticking boxes but making sure the training and support is worthwhile and benefits people who use the service. Staff are supported during supervision and appraisal to achieve good results."

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005) and DoLS or were enrolled on a course.

All the people we spoke with and from the records we looked at people had the capacity to make their own decisions and had signed their agreement to care and treatment. They also had tenancy agreements with the company who owned their properties. The registered manager was aware of the services responsibility to hold and record best interest meetings. We saw that 12 best interest meetings had been held, one DoLS had been authorised and they were waiting for the local authority to process the remaining 11. This meant people's rights were protected.

We saw from the documentation we looked at that people had access to specialists, either within the company or from other organisations such as hospital consultants. Staff also supported people who used the service to attend routine appointments at opticians, dentists and podiatrists when required. Each person also has their own GP. This meant people received up to date medical care.

Good

Is the service caring?

Our findings

People who used the service said, "The staff are kind and look after me when I am poorly", "The staff are OK. The staff help me nearly every day. I get the same team and they are all fun and kind" and "The staff are all nice. The staff know how look after me."

Staff members said, "I like working at this service. I think this job is rewarding and I have helped this person improve. It is good to see people moving into independent living. I would be happy for a member of my family to use this service", "I like helping people improve their lives" and "I would recommend this service if a family member needed it."

People who used the service said they were encouraged to maintain contact with their family and friends. One person went on holiday with family. All the people we spoke with said they were supported to maintain links with their families and friends.

A person who used the service said, "I have just competed in the Manchester 10k run – it was my second. I do lots of 10k runs and we do lots of training in the park." This person's member of staff said, "I like the fact there are a lot of outdoor activities, we use the gym and go out every day during the summer." This member of staff and the person who used the service had been matched together so that the person who used the service could follow their passion for running. They trained and ran in various community arranged events. The person who used the service was grateful for this support although did tell us he was a better runner than the staff member who laughed and agreed. There was a bond between all the people who used the service and their staff members who came to talk to us. We spoke with them together and it was good to see the trusting and caring relationships they had.

During the inspection we observed how staff and people who used the service interacted. Staff were polite yet had a friendly approach which created a good atmosphere between them both. We also saw a good deal of laughter and light hearted banter. This type of atmosphere was beneficial to people with Autism and/or learning disability.

Staff were trained in confidentiality topics and we saw that records were stored securely to keep them private.

Some staff had attended end of life care and although the service did not have end of life plans for every person we saw the sympathetic way this was approached if required. One person had lost a family member. Staff had told the person what the illness had been, things that could help him stay well, what happens when we die (the process such as undertakers), what happens at a hospice and how he can remember his family member. To ensure the person understood what was being said staff used pictures to help explain what they were telling him. Because the person was worried an advanced care plan was being discussed. The plan so far contained the person's personal details, who supported him, his next of kin, who else the person wanted to be involved, where the person would like to be cared for, who should be informed if seriously ill, what clothes to wear and any flowers or music the person wanted. The registered manager said

a plan such as this one would be completed if any person who used the service needed similar support. However, we said it would be good practice for all people who used the service to at least have some details recorded for their last wishes. Although people who used the service were all younger adults anyone can have a life threatening illness or accident.

We saw that people's ethnic and diverse needs were met. One person prayed with family, another attended church and one female person requested and only had female staff support her. We were told that religious festivals were upheld and people could follow their faith in the way they wanted to.

We saw that there was a lot of personal information in the plans of care which included family background, past medical history, records of any behaviours that challenge, activities and interests. Choice and how best people could attain an independent lifestyle was also recorded as was their preferred method of communication, their faith or any cultural needs. This gave staff the information they needed to care for each person individually.

Staff were given a sense of what it may be like to see through the eyes of someone with Autism. Use of equipment, for example goggles showed how people's sensory perception may differ if they suffer from Autism. This showed staff why sensory perception was assessed as part of a care package. We tried two pairs of goggles and found the experience confusing.

Staff completed a voice and choice book. Staff recorded what people said and what action staff completed. We saw that new board games had been bought for one person and after a person had mentioned a family member staff supported the person to contact them.

Good

Is the service responsive?

Our findings

People who used the service said, "I go to see my mother on a Friday and also go to my aunties. I go on holiday with my family. We go camping. I like to watch films and pamper sessions. My carer helps me when I need my hair cut. I go to the youth club, the gym, voice training for singing and go to clubs singing. We also go to the cinema and bowling. I go to the farm and I especially like that", "I go out to shop and I can choose what I want to buy for my clothes or other items. I watch television sometimes because I am tired when I come home from work. I go to the kennels where we do singing and concerts. We are rehearsing for a show in the local community. I helped build the shed. The place is well laid out. I am saving for a new car. I went to Cyprus for some holidays and we stayed in a villa with a pool" and "I like to go to bingo. I go every Wednesday. I also like to go on the canal boat and we have a chippy lunch. It goes from Warrington to Lymm and it's a full day." (The shed and kennels were described to us by the member of staff. It is a recording studio behind some kennels where people go to rehearse and practice for group and individual performances in the community. It was well equipped and professionally run).

We saw photographs and were told by people who used the service of their involvement and participation in community events like the Manchester Day parade. People could attend activities independently or as part of a larger group providing entertainment through song and dance. We saw photographs of people enjoying themselves when they put on concerts.

We saw that people had many opportunities to engage in activities of their choice. This was often done in stages and used as a means of being more independent. An example we saw was one person wanted to go rock climbing. The person was taken to an indoor rock climbing centre, had a coffee and watched how it was done before making a decision to join in another session. Another example was a second person was being supported to know what equipment to take for a specific activity. The person had to choose the correct bag of equipment for the activity. This helped the person know where they were going and what they were doing. For this person choosing the correct equipment also meant he could get ready more independently. A third example we saw was from a person who wanted to go to New York. The person was shown New York in a brochure, assisted to get a passport, went on a flight simulator, went on a short haul flight to London and then on holiday. This was good practice for a person with Autism or learning disability. The careful planning showed how the service had ensured that the person could tolerate a new situation such as flying and therefore it was safe for himself and the community.

People helped plan their weekly activity schedule. This showed the service were committed to arranging activities that were person centred, which in turn positively impacted on people's well-being. If people could not communicate verbally different techniques were used depending upon what worked best. Some staff used recognised systems such as Makaton or used pictures and photographs to help people understand what was being offered. We saw that each person had a section of their care plans devoted to their communication needs.

People who used the service told us, "I have been to college skills for life. I learned Maths, English and IT. We also go on hikes and learn how to cook. I like it", "I have been working today. Work experience and I enjoy it. I

also work at the farm two days a week. I collect eggs and do other jobs" and "I work here in the office. I like working. I am learning new skills." This helped people feel a part of the community and gave them a sense of worth. Life skills were also part of a person's activity program. This included the running of the house, cooking, cleaning and financial management. People were encouraged to go to college or work to help fill their days with worthwhile activities.

People helped plan their weekly activity schedule. If people could not communicate verbally different techniques were used depending upon what worked best. Some staff used recognised systems such as Makaton or used pictures and photographs to help people understand what was being offered. We saw that each person had a section of their care plans devoted to their communication needs.

People who used the service said, "I can talk to my carer if I have any worries or my family", "I could talk to a member of staff if I had any concerns" and "I would talk to staff to staff if I had any worries and they would listen to me" and "I can talk to any of the staff or my family if I was worried about something."

Each person had a copy of the complaints procedure and where required this was in an easy read format. There was a photograph and phone number of the staff people could raise any concerns with which meant they knew who to talk to. There were also the details of other organisations people could contact which included the local learning disability centre, the Care Quality Commission and the complaints Ombudsman. We saw the registered manager audited any complaints made to or about the service to minimise or resolve any further issues. One example we saw was where the local authority wanted to stop a person smoking in their own home and staff had defended this person's decision to do so, another was around noise which was resolved and one protecting a person who used the service from harassment by a member of the public. The service responded to any concerns raised.

People who used the service were assessed before they moved into the home. This included visits to the home to check how a new person would fit in with existing people who used the service and to assess the person to see which staff member would best match their profile. This may take several weeks and involved the person, their family if appropriate and other organisations involved in the person's care. This was recorded and with the effort made to ensure the placement worked should mean the person was suitable to live at the home and mixed with others and staff. Some people lived independently by choice although the process was the same with the exception of not needing to mix with other people who lived at the home. If a person was able to easily tolerate the move it could be arranged much quicker.

Each person was given a welcome pack and an induction to the home they were moving into. This gave people valuable information which included access to the property, photographs of the property – internally and externally and the staff team. Each person was given a service user guide with picture support which told people what the service provided, respect for privacy, specialist services like speech and language therapy, the range of activities, what organisations the service worked with, how the service provided support, how people who used the service needed to agree to their support, things care staff should not do such as shout, hit or touch inappropriately, make fun of them, steal money or belongings or make them scared. This was backed up with the complaints procedure. The documents also gave information such as tenants meetings and other support such as finding jobs or going to college. The induction was completed during the assessment process and when they moved into the home. This showed us the service was committed to providing a safe and supportive environment for people who used the service.

The plans of care were detailed and gave staff sufficient details to deliver care appropriate to each individual's needs. Plans of care were broken down into specific headings for each identified need a person had. The personal care plan told us the basics of who the person is and what they liked or did not like. There

was a section called an essential life plan. This told us what the plan was for and who developed the plan with the person who used the service. It told us about the person's condition and how it affected them. We saw that there was a section for what people thought about them, which was completed in a positive way, what people really needed to know about the way he lived (the person needed a rigid structure), how the person needed regular time after activities to wind down alone, family dynamics and visits, who the person thought was important to them, activities the person liked and ways to make it more enjoyable, food preferences and more of the person's likes and dislikes. The activity schedule was listed and how staff should communicate with the person. The significant amount of detail in plans of care supported people to gain independence, improve their daily living skills, gain confidence and move to more independent living. Examples of this were working in the community or performing in shows for the public.

Care plans clearly laid out for staff how a person could communicate. This was to make sure they were understood and for one person this reduced anxiety. There were descriptions of what was termed a better day. This included preferred times of getting up, personal care support, breakfast routine and how staff needed to use activity cards for planning what was next. This was completed for the day. There was a record of the pictorial and photographic records of the aids people needed to communicate effectively. There was a description of what staff needed to do to help the person understand what the action was. We saw examples of how staff should help a person which included an example of how staff should pretend to hold a cup for a drink and a photograph of someone doing it. This was completed for many tasks and gave staff the tools to use simple pictures and actions to know what a person wanted or was feeling.

An 'opportunity plan' recorded what was achieved when people did an activity, for example, one person was assessed for the amount of support which was needed to buy a newspaper. The plans were reviewed regularly by the service and monitored by the local authority to see what progress was being made.

There was a strategies file which told us of each person's schedule, full daily routine record, any equipment or support required when in the community such as crossing the road, attending appointments and activities which posed a danger, for example swimming and horse riding. This was reviewed monthly to ensure that staff had up to date information when supporting people. This showed the service adapted to people's changing needs. There was a section for risk management. We saw that the risks assessed also gave staff strategies to minimise any risks and how behaviours that may challenge could best be diverted. Staff were given details of what strategies to use to spot or defuse any potential situations. For one person we saw this was for both within the home for activities or when accessing the community. This meant staff were given information to support this person's behaviours at all times. There was a record of any incidents that occurred and a management review was held to see if there were any strategies that could be formulated to minimise further risks.

There was a health action plan which recorded all the details of the person's condition, the names and contact details of all the professionals the person saw, what support staff needed to provide to attend appointments, a past medical history, a mental capacity assessment and who was responsible for providing health care input. The plan covered all aspects of a person's care from top to bottom, any treatment given and also included any pain relief a person may need. This ensured received adequate support in relation to their health care needs.

Staff completed a daily log which recorded what a person had done each day, where they had been, any incidents or illness, what they had eaten or drunk, any medicines administered and personal care given. This was recorded in 30 minute segments throughout the day and gave a very detailed description of a person's daily life. This gave staff and managers detailed information to ensure the plan of care was working for the person.

The service also completed a service user teaching progress log. This looked at specific tasks the person needed or wanted to know and was monitored until the person managed to complete the task correctly before looking at new tasks. We saw that one person was progressing towards becoming more independent in getting ready for activities. This meant the service were committed to helping people reach their goals and become as independent as they could be.

The plans were all reviewed regularly. We saw that each person had a full yearly review of all their needs.

Good

Is the service well-led?

Our findings

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

People who used the service said, "The registered manager comes to the house and talks to us. He eats all the biscuits (joking). You can talk to him. He is nice" and "All the staff are approachable, including the managers who we see at home or here in the office."

Staff told us, "Management are supportive. If you need to you can get hold of the registered manager", "You can get hold of a manager if you need to. They are all supportive" and "I get support from management. I have daily contact with the manager even if it's just for a chat."

There was a management structure staff could understand and all the people we spoke with thought the managers were available when they needed them. The service provided staff 24 hours a day with an on call management system to support care staff. We observed that staff knew the people they looked after well and gave them the support they needed.

Before the inspection we saw the registered manager had notified us of any incidents. We saw there were systems in place to audit incidents, complaints and accidents to help minimise them.

There were policies and procedures for staff to follow good practice. We looked at several policies which included safeguarding, infection control, whistle blowing, health and safety, medicines administration, confidentiality and complaints. The policies were reviewed regularly to ensure staff were supplied with up to date information.

We found there was a robust system of quality assurance. There were a number of weekly and monthly checks and audits including; care plans and risk assessments, accidents and incidents, health and safety, medicines, concerns and complaints, training, the environment people lived in, supervision and appraisal, a person's quality of life. The registered manager said they could spot when a service was declining but also used the results of the audits to raise standards.

Each house people lived in had a written document of the standards and ideals which best suited people who used the service. This was developed by staff and people who used the service. The aims of each service were discussed and what actually was required for people who lived at the home. We saw the document included topics such as respect and choice, staff competencies, being healthy, staying safe, relationships and community presence. This was then laminated and displayed in the relevant house to remind staff of what they wanted to achieve. This gave staff and people who used the service input into how the service was run. People who lived at the service had meetings called 'Tenants Voice' to have their say in how the house

was run. Staff used each person's individual communication methods to ensure they were aware of people's needs.

Families were invited to attend a 'forum'. This gave families a chance to bring up their ideas upon how to improve the service as a whole or for their own relative. We saw that following one meeting the service had improved their communication methods with a person who used the service from the ideas of their family member.

The service produced a magazine called Maxlife. This recorded what activities people had engaged in, staff news, new facilities, money raised for charity, birthdays, work experience of people who used the service, a staff wedding, a person and staff member competing together in the Manchester 10k run and news around the service.

The service had a development and project plan for 2016. This set out the company's plans for the year and how they wanted to provide more services. The document set out what the service wanted to achieve which was to invest in commercial schemes for people to achieve financial independence, meaningful work and boosting people's confidence and self-esteem through vocal and dance performance. The service were developing schemes with the local authority and employers for the benefit of people who used the service. There was a drive for periodic service reviews, which looked at management performance to help provide consistent quality of service, identify strengths and weaknesses and act to improve the findings. All staff were involved in the process. This was a 36 page document which in general terms showed how the service was thinking and acting to improve the quality of care they provided.

Staff were issued with a handbook which contained key policies and procedures such as confidentiality and whistle blowing, good practice guidance, health and hygiene and training expectations. This document gave staff information about how to perform their roles to a good standard.