CareQuality Commission

William Morris (Camphill) Community Limited

William Morris House

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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

William Morris House is a specialist residential college that forms part of the Camphill Community. The service is registered to provide accommodation and personal care for up to 35 young people with a learning disability or autistic spectrum disorder either during term time or a full-time 52 week placement. The Care Quality Commission (CQC) regulates and inspects the accommodation and personal care. The educational provision at the college is regulated and inspected by the Office for Standards in Education (OFSTED).

At the time of this inspection eight people were using the service. Five people using the service lived in one house (Hiram) three people in another (Merton). Additional accommodation was being used for activities and staff training with some being refurbished to provide more independent flats.

At our last inspection in November 2015 we found, a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because, people's capacity to make choices and decisions and consent to their care and treatment, had not been assessed and any restrictions upon people's liberty had not been identified. At this inspection we saw the provider had taken the action they had identified in their action plan. As a result improvements had been made and the service was no longer in breach of this regulation.

At the last inspection, the service was rated Good overall.

At this inspection we found the service remained Good.

Why the service is rated good:

The service was designed and delivered around the individual needs of people, provided by caring staff who were well supported by managers and, was continually seeking to improve. We did not find any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection.

People were safe. The manager and staff understood their role and responsibilities to keep people safe from harm. People were supported to take risks, promote their independence and follow their interests. Risks were assessed and plans put in place to keep people safe. There was enough staff to safely provide care and support to people. Checks were carried out on staff before they started work with people to assess their suitability. Medicines were well managed and people received their medicines as prescribed.

The service was effective in meeting people's needs. Staff received regular supervision and the training needed to meet people's needs. Arrangements were made for people to see a GP and other healthcare professionals when they needed to do so. The physical environment was personalised and met people's needs. The service complied with the requirements of the Mental Capacity Act 2005 (MCA).

People received a service that was caring. They were cared for and supported by staff who knew them well.

Staff treated people with dignity and respect. People's views were actively sought and they were involved in making decisions about their care and support. Information was provided in ways that were easy to understand. People were supported to maintain relationships with family and friends.

The service was exceptionally responsive to people's needs. People received person centred care and support. They were offered a range of activities both at the service and in the local community. People were encouraged to make their views known and the service responded by making changes. Effective communication was maintained with relatives. Staff worked hard to ensure people's moves to and from the service were managed in a manner that minimised disruption and ensured their needs were met.

The service was well led. The manager worked closely with the strategic director and met regularly with the trustees. Trustees are responsible for making sure charitable organisations do what they have been set up for, they are unpaid and usually carry out these duties through regular meetings with the senior staff. The manager, senior staff and trustees provided good leadership and management, particularly with respect to the evolving vision and values of the service. The vision and culture of the service was clearly communicated to and understood by staff. A comprehensive and sophisticated quality assurance system was in place. This system was based upon regular, scheduled audits which fed into an overall quality improvement cycle. This meant the quality of service people received was monitored on a regular basis and where shortfalls were identified they were acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service has improved to Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service has improved to Outstanding.	**Outstanding**
Is the service well-led? The service remains Good.	**Good**

Care Quality Commission

William Morris House

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 28 and 30 March 2017. The inspection was carried out by one adult social care inspector and was unannounced. The last full inspection of the service was in November 2015. At that time we rated the service overall as 'Good'. However, we rated the service as 'Requires Improvement' under our key question heading of; Is the service effective and, identified a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider sent us an action plan detailing the action they would take to ensure the required improvements were made.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also reviewed the most recent OFSTED report following their inspection in July 2016.

We contacted four health and social care professionals involved with the service and asked them for some feedback. Their comments have been incorporated into this report.

Some people were able to talk with us about the service they received. We spoke with five people. We spent time with people in each house and communal areas within the college and its grounds. We spoke with eleven staff, including the manager, the strategic director, office based staff, three house co-ordinators and four support workers. We also spoke with relatives of three people using the service by telephone.

We looked at the care records of six people using the service, three staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included; "The staff keep me safe", "I like all the staff they make sure I'm all right" and, "Yes, the staff make sure we're safe". We observed people in both houses and saw they reacted positively to staff and seemed relaxed and contented. Relatives said they felt people were safe.

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of situations that may give rise to a concern of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Easy read flowcharts of action to be taken if abuse was suspected, witnessed or alleged were on display in each house. Staff had completed training in keeping people safe. Staff knew about 'whistle blowing' to alert management to poor practice. The provider had appropriately raised safeguarding alerts in the 12 months before our inspection. On each of these occasions the provider had taken the appropriate action. This included sharing information with the local authority and the Care Quality Commission (CQC).

There were comprehensive risk assessments in place. These covered areas of daily living and activities the person took part in, encouraging them to be as independent as possible. For example, risk assessments were in place to keep people safe from harm when carrying out domestic activities such as cooking and for people to use community leisure facilities safely. Risk assessments contained clear guidance for staff and detailed the staff training and skills required to safely support the person. Assessments were regularly reviewed and were based upon individual activities people wanted to do. Where people required support to help them manage their behaviours, plans had been put in place. These identified how they, and others, would be kept safe at times of heightened anxiety, anger or distress. Staff told us that people generally got on well with each other but staff needed to support and maintain this. Strategies were in place to guide staff on how each person should be supported to minimise the risks to others.

Accident and incident records were completed and kept. These identified preventative measures to be taken to reduce the risk of reoccurrence. Staff also documented 'near misses'. The manager explained these were occasions where no harm had come to anyone but due to the circumstances it may have done. They said this allowed them to take preventative measures before anyone came to harm.

As a result of specific health conditions some people required additional measures to be in place to keep them safe. For example, one person told us how they were supported to wear a 'watch' at night that sent a signal to staff if they had a seizure. They were happy to talk with us about this and said it made them feel safe. Staff told us this system worked well.

Relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous

employers. The service made use of volunteers. Where volunteers were recruited who were non UK residents, it was evident from their files that the relevant immigration checks were undertaken prior to employment. Recruitment procedures were understood and followed by the manager. People using the service were involved in the recruitment of new staff.

People were supported by sufficient numbers of staff to meet their needs. Staff were allocated to work in individual houses and with specific people. Staff rotas identified senior staff and an on call person who could be contacted at any time of the day or night. The service had a stable staff team and made use of agency staff to ensure staffing levels were maintained. People said they were able to receive care and support from staff when they needed it. Staff said there were enough staff to safely provide care and support to people. During our visit we saw there was enough staff to meet people's needs.

There were clear policies and procedures for the safe handling and administration of medicines. These were followed by staff. Medicines were securely stored and records of administration were kept. Staff had received training in administering medicines. Following this training the manager assessed the ability of staff and signed them off as competent to safely administer medicines. Some people were prescribed 'as required' medicines. These were to be administered when people needed them for medical emergencies, pain relief or to reduce anxiety. Clear plans were in place to ensure staff knew when and how to administer these.

Staff had access to equipment they needed to prevent and control infection. This included protective gloves and aprons. The provider had an infection prevention and control policy. Staff had received training in infection control. Cleaning materials were kept in locked rooms to ensure the safety of people. The accommodation was clean, well maintained, odour free and appropriate for the young people.

Good

Is the service effective?

Our findings

People using the service told us their needs were met. Relatives said they felt people's needs were met. Staff we spoke with told us people's needs were met.

The service had a programme of staff supervision in place. Supervision meetings are one to one meetings a staff member has with their supervisor. The manager carried out supervisions with house co-ordinators who in turn supervised support staff. Staff members told us they received regular supervision. Staff records showed that supervisions were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Each staff member knew who their supervisor was and all said they found their individual supervision meetings helpful.

People were cared for by staff who had received the training to meet people's needs. We viewed the training records for all staff. These were well-maintained and identified when staff had received training in specific areas and, when they were next due to receive an update. The core training completed by staff included; first aid, infection control, fire safety, food hygiene, administration of medicines and safeguarding vulnerable adults. Specific training to meet people's needs was also provided, for example, training in administering emergency medicines.

In addition, the service organised and ran what they called 'person-centred focus sessions' at regular intervals. These were organised so each staff member attended a total of four weeks a year. These sessions focussed on each person and, involved the whole staff team contributing to their outcomes, targets and objectives. We saw records of these. Staff told us they helped highlight what was important to each person including their likes, dislikes, wishes and aspirations. They said this enabled them to share best practice in providing the person's care and support and allowed for both learning and further development of their care plans, risk assessments, behaviour management plans and contributed to achieving outcomes for people. Staff said the training they had received had helped them to meet people's individual needs. They were particularly enthusiastic regarding the 'person centred focus sessions'.

Newly appointed staff completed induction training. An induction checklist ensured staff had completed the necessary training to care for people safely. House co-ordinators told us new staff shadowed experienced staff as part of their induction training. Staff confirmed they had received an effective induction.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff had received training on MCA and DoLS. Care plans contained an assessment of people's capacity to make specific decisions. These were individual to the person and identified when the person was most likely to be able to make a decision and how it should be explained to them to maximise their understanding.

The provider had submitted applications for DoLS authorisations for a number of people. This was because the person lacked capacity to make a particular decision and their liberty was being restricted. These applications had been submitted to the appropriate authorities in a timely manner. Best interest decision making was used effectively to ensure any restrictions were minimised and appropriate. For example, this process had been used to limit one person's access to computer technology as the resulting 'over stimulation' had caused them difficulties with concentration and anxiety. A system was in place to monitor the progress of these applications, which included dates any had been authorised and when they would lapse. This meant the provider was able to manage this process to ensure people would not be deprived of their liberty without the correct authorisation being sought. Clear records were kept of consultation and reviews with the relevant person's representative (RPR) where authorisations had been received. The manager understood they needed to submit a notification to CQC whenever a DoLS authorisation was received.

People chose what they wanted to eat. Menus were planned with the involvement of people using the service. Food provided was varied and included a range of choices throughout the week. People were encouraged to participate in the preparation of food. Participation was planned and people said they enjoyed doing this. People told us they enjoyed the food. Staff said care was taken to ensure food was wholesome, well-balanced and nutritious. At lunchtimes we saw people interacted well with each other and staff and enjoyed the food and social engagement. People's dietary and fluid intake was monitored and recorded.

Staff were skilled in communicating with people and college-wide approaches to seeking and responding to their views were in place. This included regular house meetings which gave a voice to people and a clear line of communication with senior managers. Assistive technology was widely used in both the residential and educational areas. This included hand held computers and individual communication cards and symbols. For example, a number of people used individual communication cards to help them communicate with staff and others. Health and social care professionals such as speech and language therapists and psychologists had been involved in developing these and regularly reviewed their effectiveness with people and staff, to ensure a consistent approach.

People's care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs in these areas and were regularly reviewed. There were detailed communication records in place and records of hospital appointments. People had health plans in place that described how they could maintain a healthy lifestyle.

The physical environment in both houses was of a high standard and met people's needs. Communal areas were homely and people's own rooms were personalised. People who showed us their rooms were proud of them. When necessary repairs were identified these were quickly acted upon. Each house had clear notices and signs, to assist people to find their way around. Notices on fire evacuation were in easy to read language and made use of pictorial information to make them easier for people to understand. The provider had

plans in place to further develop the facilities available to people. The external environment at the college was tranquil and well-maintained.

Good

Is the service caring?

Our findings

People told us they liked the staff and thought they were caring. We saw that people were treated in a caring and respectful way. Relatives told us staff were caring. One relative said, "The care is really good". Staff were friendly, kind and discreet when providing care and support to people. Health and social care professionals also confirmed staff were caring. On said, "All the staff at William Morris have a very caring and respectful manner in the way they communicate with the residents and students. They are never rushed or shown any impatience".

People were cared for by staff who knew them well. Staff were able to tell us about people's interests and individual preferences. People responded positively to staff, often with smiles, which showed they felt comfortable with them. We saw a number of positive interactions and saw how these contributed towards people's wellbeing. At lunchtime for example, we saw staff interacting with people including laughing and joking together.

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. People's care records included a communication plan which described how people's communication needs were met. A variety of communication aids were used to assist people with limited verbal communication. Staff were able to explain how people expressed their views. Staff spoke about people in a positive manner. They stressed people's talents and demonstrated they valued them as individuals. Each staff member we spoke with told us they would be happy for a relative of theirs to use the service.

People's care records included an assessment of their needs in relation to equality and diversity. We saw the provider had planned to meet people's cultural and religious needs. For example, specific dietary requirements were met and important festivals celebrated. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met. Staff had received training on equality and diversity.

People were supported to maintain relationships with family and friends. People's care records contained contact details and arrangements. People spoke with us about their families. Staff said they felt it important to help people to keep in touch with their families. Relatives we spoke with felt considerable efforts were made to ensure people's contact with family and friends was promoted.

Promoting people's independence was a theme running through people's care records. Guidance was included for staff on how to work alongside people providing coaching to carry out activities themselves. Staff told us they saw this as a key part of their role.

Throughout our inspection we were struck by the relaxed and homely atmosphere in both houses. People and staff seemed to enjoy each other's company. People were engaged in conversation with each other and staff and there was a real sense of fun.

Outstanding ☆

Is the service responsive?

Our findings

The service provided was exceptionally person centred. It was flexible and responsive to people's individual needs and preferences, creative ways were identified and put in place to enable people to live as full a life as possible.

One person had experienced difficulties coping with living in one of the shared houses. This had resulted in increased stress and anxiety for them. Staff worked closely with professionals in the community learning disabilities team to identify positive ways the person could be supported to cope better. This had resulted in detailed plans for sensory stimulation, communication and supporting them to manage their behaviour. At the same time the provider worked with the person, their family and health and social care professionals to develop an upstairs independent living flat. They had been fully involved in choosing the decoration and arranging the flat as they wanted. The person was now supported by staff on a one-to-one basis in their flat in accordance with the detailed support plans. In addition arrangements to assist the person to enjoy visits from family members had been further developed. The person now met family in the local community rather than at the service. This was because it was felt by all concerned that this allowed them to have a clearer understanding of, and distinction between, their family home and their home at William Morris House.

As a result of these measures the person was coping much better. They told us they were happy with their flat and support arrangements. Staff spoke passionately and enthusiastically about the positive impact this had had on the person. They said their mood was much improved and incidents of heightened anxiety had decreased. Care records also demonstrated this. The person's relatives said, "They (Staff) put heart and soul into getting (X) through that period, (X) is much happier now and more stable. The move to the flat has been very successful. So much so, that we want (X) to stay on after the college course has finished". The manager said, "We made sure (X) moved at their own speed. The environment is really important; (X) now has more 'down time'. We also select the staff to work with (X) carefully as (X) needs quiet confident staff. We also minimise staff changes, although when behaviours become intense, we ensure there is a system for changing staff every two hours".

Another person had moved to the service from a different residential college in September 2016. They had needed to use incontinence pads day and night on arrival. Staff had worked closely with the person and a specialist incontinence advisor to develop plans to decrease their reliance on these. A staff member said, "We put the idea to (Person's name). (X) decided to give it a go and has done really well and doesn't use pads now. We stick to the plan of reminders and have guidance in place to help (X) use the toilet better". The person told us they were very happy they no longer needed pads. Clear guidance was in place for staff and the person to ensure they were able to sustain this. This had clearly resulted in a positive impact on the person's dignity and, their ability to engage in activities free from the need to use incontinence pads. The same person had also experienced a decrease in incidents of anger. Positive behavioural strategies had been put in place and were having a positive impact. Training on implementing these strategies had been provided through the 'person centred focus sessions'.

Relatives of other people identified to us other examples of the service providing responsive care. One relative of a person who had recently begun staying at the college one night a week said, "The transition work they did was amazing. I never thought (X) would stay. They did introductory visits and stays and kept me fully informed. I was invited to dinner with (X). To be honest I'm absolutely gobsmacked about how well they handled everything". Another relative said, "(X) has gone from strength to strength and is transferring what is learnt at college to home. For example doing laundry. (X) has learnt a lot there and is always happy to go back after coming home for the holidays. (X) is really proud of what he's doing. Staff have worked really hard with (X)". We saw in care records and were told that staff were fully involved in supporting people's transition into and out of the college. Staff said; "Preparation for new students is really good" and, "I think the transition work we do works really well". Staff liaised effectively with other organisations to make sure that the highest levels of care were in place for people coming into the service and, that people moving on had an effective transition into the next phase of their lives

At our last inspection in November 2015, relatives gave mixed feedback regarding the communication with the manager and staff, with some saying communication was not good. During this inspection we saw this had improved. Relatives said, "Communication is much better now. We feel fully informed and have really good working relationships with staff", "Staff communicate well with us, it couldn't be any better really" and, "The communication with the college is excellent". Staff felt communication between the college and families had improved. They said," Communication is really key" and "It's really important particularly with transitions between college and home to make sure communication is as good as it can be". Health and social care professionals also commented positively regarding how the service communicated with them. One said, "There is an allocated member of staff to act as a link between college and Speech and Language Therapy (SALT) so I have a point of contact when needed".

People's care records were person centred. They included information on people's life histories interests and preferences. Staff said this information helped them to provide care and support in the way people wanted. Staff we spoke with were knowledgeable about people's life histories and their likes and dislikes. People and their families had been involved in developing and agreeing their plans for how they were cared for and supported. People's care and support was planned proactively in partnership with them.

Social and leisure activities were well planned and also aimed for people to achieve their learning objectives. Each house had an activities programme in place. Activities were varied and included activities at the service and trips out. The provider had a variety of vehicles to enable people to access their local community and go on trips. People told us they enjoyed the activities. Staff said there were plenty of activities and sufficient staff and transportation. Relatives said activities were arranged based upon people's interests. Talking with staff it was clear they recognised the need for people to rest and achieve a balance between college life and leisure time

Each person had clear objectives that had been agreed with them. These identified learning outcomes relevant to both their college and residential lives. Residential staff understood the agreed outcomes and learning goals for each student. We saw agreed learning objectives were supported in both environments. This meant skills learnt by people were transferred between both. Relatives told us people had been able to transfer these skills to their family home. One relative said; "(Person's name) is transferring learning from school to home, an example of this has been travel training in learning to use buses". We spoke with staff about people learning to use public transport. They said a number of people benefitted from 'travel training'. They explained this was based around people vesting places of interest to them and included learning other skills, such as using money. We saw people had clear plans in place to achieve these learning objectives. The service also participated in the 'keeping safe in Stroud' scheme. This was a local initiative that identified specific shops that had identified themselves as safe places for people to report to. This

meant if people were in the town on their own, they had a place to go if they felt unsafe. People who used the town independently carried this information with them.

The service as a whole took a key role in the local community and was actively involved in building further links. People who used the service were encouraged and supported to engage with services and events outside of the service. Input from other services and support networks were encouraged and sustained. The manager, senior manager and staff were all aware of the potential for people using the service to become isolated as a consequence of living at William Morris House. The manager told us they reduced this risk through developing links with the local community, making use of volunteers and supporting people to participate in events and activities in the local area. We saw people benefitted from volunteering with community groups such as; the Canal Trust, the local football team, providing rugby training at local schools and involvement with a number of other locally based activities. People we spoke with were enthusiastic regarding these activities.

The provider used well planned, individual ways of involving people so they feel consulted, empowered, listened to and valued. Regular meetings were held with people to seek their views regarding their care and support. Staff supported people to use augmentative communication systems at these meetings to help them contribute. One particular staff member had responsibility was responsible for ensuring meetings were effective. People said they enjoyed these meetings and felt their views were listened to and acted upon. Records of these meetings were kept. These were produced in an easy to read format using the headings of 'You said' and 'We did'.

The provider had a policy on comments and complaints. The policy detailed how complaints were responded to, including an investigation and providing a response to the complainants. An easy read version of this policy was on display in both houses. A record of complaints was kept at the service. The provider had received three complaints in the previous 12 months. Two of these related to communication between the service and parents, one concerned a person undertaking a specific activity. Each had been investigated and feedback provided to the complainant regarding the outcome of the investigation.

Good

Is the service well-led?

Our findings

There was no registered manager at the service 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. The service had been without a registered manager since our last inspection. However, the provider had ensured the service was managed by an experienced person and submitted notifications and kept CQC informed of management arrangements. The manager had now submitted an application to CQC to register as manager and was awaiting their 'fit and proper person' interview.

The service had a positive culture that was person-centred, open, inclusive and empowering. There was a good understanding of equality, diversity and human rights and these were put into practice. Throughout our inspection we found the manager demonstrated a commitment to providing effective leadership and management. They were keen to ensure a high quality service was provided, care staff were well supported and managed and the service promoted in the best possible light. We were made to feel welcome by people and staff and managers who all responded to us in an open and transparent manner. Senior staff provided us with information we requested promptly and, relevant staff were made available to answer any questions we had. This was done in such a way, that it did not negatively impact upon the service provided to people.

People told us they liked the manager and senior staff and were able to talk to them when they wanted. Staff spoke positively about the management and felt the service was well led. Relatives also felt the service was well managed.

Services provided by the Camphill Community have traditionally been based upon specific values outlined within their aims and objectives. At our last inspection in November 2015 we reported on the senior staff and trustees having implemented changes to 'modernise' the service. This had continued and during this inspection it was clear the service provided was even more person centred, whilst some of the more traditional elements such as celebrating certain festivals and a focus on people spending time together as a community, retained. Staff and relatives commented positively on these changes. Staff at all levels understood the values and culture of the service and were able to explain them. The manager and senior staff said these measures and continued improvement planning had put them in a position where they now felt they could seek to increase the numbers of people using the service.

The staffing structure had recently been altered. The manager told us this was to provide more effective role modelling, coaching and support to staff. The manager now oversaw three house co-ordinators, who in turn managed senior support staff and support workers. Staff we spoke with understood the management structure and felt it provided effective leadership.

The provider operated an on call system for staff to access advice and support if the manager was not present. Staff confirmed they were able to contact a senior person when needed. House co-ordinators were responsible for the service when the manager or other senior staff were not present.

The policies and procedures we looked at were regularly reviewed. Staff we spoke to knew how to access these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

All accidents, incidents and any complaints received or safeguarding alerts made were followed up to ensure appropriate action had been taken. The manager analysed these to identify any changes required as a result and any emerging trends.

The manager and senior staff knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriate notifications made by the service.

A well planned, comprehensive and sophisticated quality assurance system was in place. These consisted of a schedule of monthly audits carried out in each house by senior staff. Audits completed by the manager included medicines management, health and safety, financial audits and care records. These audits were carried out as scheduled and corrective action had been taken when identified. The audits fed into an overall quality improvement cycle that allowed senior staff and trustees to effectively monitor the quality and safety of the service.

Health and safety management was seen as a priority by senior staff. A health and safety manager had been employed. They had developed a robust system for health and safety checks. As a result of these checks being carried out action had been taken to minimise identified health and safety risks for people using the service, staff and others. The system of health and safety checks fed into the overall quality improvement cycle that was overseen by senior managers and trustees.

Copies of the most recent reports from CQC and OFSTED were on display at the college and were accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily assess the most current assessments of the provider's performance.

At the end of our inspection feedback was given to the manager and strategic director. They listened to our feedback and were clearly committed to providing a high quality service valued by people and families. They spoke with us about their future plans for the growth and development and, improvement of the service provided to people.