Ormerod Home Trust Limited (The)

The Ormerod Home Trust Limited - 2 Headroomgate Road

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

The Ormerod Trust is a registered charity that provides care and support to adults and children with a learning disability across the Fylde, Blackpool, Wyre and Lancashire. People are supported in their own tenancies and services are designed around their personal care needs. Other services provided by the Trust include specialist support with complex needs, daytime opportunities and support to access local community facilities.

We last inspected this location in July 2014, and the service was found to be compliant with the regulations it was inspected against. Shortly after this inspection in July 2014, the chief executive (appointed December 2013), undertook a review of the systems and procedures operated by the service. Polices were updated to reflect current best practice and new legislation such as the Care Act, easy read documents were produced for tenants to use and a new quality assurance was introduced.
The registered manager was on duty when we visited the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to our inspection visit, we were notified of an allegation of financial abuse. The local safeguarding team and police were involved in the investigation of the allegation. The allegation centred on missing finances. This matter had been dealt with by the Trust, and lessons learnt from the incident had led to changes and improvements to the finance recording systems operated by the service.

The Trust provides services to a small number of people who do display challenging behaviours; the number of safeguarding alerts is higher than expected. In discussion with the chief executive, we were reassured that this higher than expected figure was not necessarily as a result of staff being unable to deal with situations, or because risks had not been properly assessed. The underlying reasons can be attributed to the unpredictable nature of some of the behaviours displayed by individuals and the clash of personalities between tenants. The Trust had good systems in place to ensure that incidents were properly reported. On occasions, incidents or situations that were not later defined as a safeguarding issue, were reported: this showed that the Trust had an open and transparent culture.

Staff knew what to do and who to contact if they thought anyone was at risk of harm. Risks to individuals had been identified and plans were in place to make sure risks were kept to a minimum. Where people needed their medicines to be administered by staff, there were clear procedures in place to make sure administration was carried out safely. Door wedges were seen to be used in tenant's homes to keep doors open, some being designated fire doors, and we made a recommendation that the Trust seek advice and guidance from the local fire service regarding their usage.

There were enough staff, of suitable skill and character to make sure people's needs were met. Before new staff started work, the provider carried out proper checks to make sure they were fit to work at the service.

Staff were able to attend training that provided them with skills and knowledge to carry out their roles effectively.
Staff had a good understanding of the requirements of the Mental Capacity Act 2005 (MCA). Appropriate action had been taken to make sure legal requirements were followed where restriction on a person's movement was a concern.

People received the support they needed with their personal care. Where people had particular health needs there was clear information about the support people required. Staff were aware of individual preferences and how best to assist people in the way they wanted. They demonstrated a caring and warmth in the way they discussed the people they supported. People had regular reviews of their care and support to make sure any changes in needs were identified and acted on.

The registered manager had been in post since September 2014. They had a good overview of the service and had identified areas that needed to be improved. In particular there had been a number of changes in management over the last few years and this had positively affected staff morale. The registered manager was keen to provide a consistent and open management style.

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.

Despite a recent allegation and a high number of safeguarding alerts linked to challenging behaviour, staff had a clear understanding of their safeguarding responsibilities and incidents had been dealt with in the correct manner.

There were good systems in place to protect people from the risks associated with their personal care needs.

There were sufficient numbers of suitably qualified and experienced staff to meet people's needs.

There were safe systems for the administration of medicines.

Is the service effective?

Good

The service was effective.

Training offered by the Trust was comprehensive and based on current best practice. Staff had the knowledge and skills to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and legislative requirements were followed.

People were supported by staff to maintain good health. Appropriate support was provided with eating and drinking where this was needed.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in making decisions about their care and support.

Staff treated people with respect and maintained their dignity when supporting with personal care.

The service had good systems in place when considerations

needed to take place regarding end of life planning. People were supported to be involved in their process, and best interest meetings would take place if people were unable to contribute due to their lack of capacity in this area.

Is the service responsive?

Good

The service was responsive.

Care planning was based on recognised Person Centred Planning techniques which incorporate best practice in this area.

Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People were reminded of their right to make a complaint in a way that they understood. Complaints were responded to appropriately by a manager.

Is the service well-led?

Good

The service was well-led.

The quality assurance systems operated by the Trust were based on best practice. There was effective management of the service. Areas for improvement had been identified and appropriate action was being taken where necessary.

There were effective systems in place to make sure that the service continued to deliver good quality care.

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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 2 and 3 November 2015. As the service is a community based organisation, we gave the service 24 hours' notice of our visit. This was to ensure that both the registered manager was present at the inspection, and so that arrangements could be made for members of the inspection to visit the houses of tenants supported by the service provider. The inspection was carried out by the lead adult social care inspector for the service, a second adult social inspector, and Specialist Professional Advisor with a background in providing services to adults with a learning disability.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports.

During this inspection we visited the Trust's head office, and visited 3 tenancies. Some people who used the service had complex needs; some of them were not able to tell us about their experiences, so we looked at their records and spent time with them observing how they interacted with the staff, and how the staff engaged with them. We looked at five people's care planning documentation and other records in detail. We also reviewed management files including four recruitment records, staff rotas, notifications, records of meetings, medicines records and quality assurance records. We spoke with seven members of staff, a service

manager, the human resources manager, the registered manager and the chief executive of the Trust. We also spoke with one relative over the telephone.

Good

Is the service safe?

Our findings

We spoke to four relatives about how safe they thought the service was. The feedback we received was positive. One person said, "My relative's needs are very complex, and the staff do a great job in keeping them safe. I have no problems with the way they care for my relative." Another said, "This placement is the best my relative has ever had. The staff take them out and they do lots with them. I have no concerns or worries about safety."

We spent time with seven tenants in order to see how they were supported to live their lives in a safe and supportive environment. As the tenants did not all communicate verbally, we spent time observing their interaction with the staff and each other, and through concentrating on their body language and non-verbal cues, tried to get a sense of how they felt. How the tenants expressed themselves and moved around their home, gave us a sense of how they felt about their environment. People were seen to move freely and safely around their homes. The staff explained that they were very familiar with people's non-verbal cues, especially those that expressed dissatisfaction, concern or unhappiness. Staff were seen to observe people for these signs as when presented they may be an expression of feeling unsafe or insecure. Staff were seen to have written procedures of responding to these non-verbal cues in order to maintain people's safety and offer reassurance.

Prior to our inspection visit, we were notified of an allegation of financial abuse. The local safeguarding team and police were involved in the investigation of the allegation. The allegation centred on missing finances belonging to a tenant that had been removed by a former staff member. The staff member has since left the Trust, and disciplinary procedures were seen to be underway regarding this person, and a police investigation was on - going. Following the recent investigation into alleged financial abuse at one of the tenancies, the Trust introduced a new, more robust financial recording system. Details of this are given within this report under the Responsive section.

Following our inspection visit, we were contacted by a family member of a tenant. They told us that they felt the service was safe and suitable. However, they spoke about a recent incident that they had with the Trust management regarding a fall their relative had experienced following a seizure. They explained that they had visited their relative, and noticed a bruise on their head. When investigated, this bruise had been as a result of a fall, which had not been recorded by staff at the home. The relative was concerned that no record had been maintained relating to the action by the staff in response to the fall, e.g. medical checks. The relative explained that although this was a concern, it was the first time this type of incident had occurred. The details of this incident were passed onto the Trust management by Care Quality Commission (CQC) and we asked for a full explanation of the events leading up to and following it, so that we could fully understand the circumstances, and make a judgement.

Despite this query from a relative, we found that periodic analysis of accidents and incidents was carried out by the management team. This was further reviewed at Trustee meetings and lessons learned from these were openly discussed. Following this discussion, any action that needed to be taken was done so promptly. Where appropriate, investigations had taken place. These were completed by the registered manager, or

their delegated representative. We saw that where trends had been identified, appropriate action had taken place. As the Trust provides services to a small number of people who do display challenging behaviours, the number of safeguarding alerts is high. In discussion with the chief executive, we were reassured that this high figure was not do necessarily as a result of staff being unable to deal with situations, or because risks had not been properly been assessed. The underlying reasons can be attributed to the unpredictable nature of some of the behaviours displayed by individuals and the clash of personalities between tenants. One person who did not get on with their co-tenant was recently supported to move and the number of incidents had dropped considerably.

Staff members told us that they felt confident about identifying potential abuse and taking appropriate action. They had received clear guidance and training about safeguarding issues and procedures. One staff member told us, "In my induction we went through the signs of abuse, our duty of care and what action to take if we had concerns".

There was an up to date and comprehensive safeguarding policy in place which included safeguarding guidance from other organisations, such as the CQC. The registered manager told us that there were senior managers in the organisation who could be contacted at any time for advice or support. We saw that the proper authorities had been informed where safeguarding concerns had been identified. Any incidents or accidents had been recorded and then reviewed by a manager to assess if there was anything that could be done to prevent a reoccurrence. Reporting concerns and safeguarding issues was important to staff and the Trust. All incidents of this nature were reported, despite the fact that some incidents may well have been later defined as not being a safeguarding incident. This showed that the Trust had an open and transparent culture.

We noted that in some of the tenancies, doors were propped open with wedges. We acknowledged that due to the nature of the properties and capabilities of some the tenant's doors were propped open for convenience, as people wanted to move around their homes freely. Up to date risk assessments were in place for each person. These described risks to the individual and control measures to keep any risks to a minimum. For example, one person was at risk of injury due to occasional seizures. Although there was clear guidance in place about how to keep the person safe in different situations, such as in the car or in a bath, some of the information was located in different parts of the person's care file. The service manager explained that a number of care files were in the process of being revised. This was to ensure that the most important information about a person's daily life, and any risks associated with their care, was put together in an easy to access file. We saw evidence of care files that had been revised, and found the information was straightforward to follow and a lot easier to use. We saw an epilepsy support plan which included guidance about indications, triggers, what to do and when to call an ambulance. This meant that staff had the information they needed to provide a consistent approach and were able to support the person in tasks and activities whilst keeping them safe.

Some people required their medicines to be administered by a member of staff. There were good systems in place to make sure that these medicines were managed safely. Support plans provided detailed information about each person's medicines, including why it was needed and possible side effects or allergies. Risk assessments were in place and these explained the action to take if medicines were refused or given later than prescribed.

Medicines were stored safely in a locked, secure cabinet. A medication administration record (MAR) was used to show the medicines to be administered, dosage and time taken. Staff signed the MAR after medicines had been administered and we saw that there were no unexplained gaps or errors in recording over the last few weeks. There was a staff rota for each supported living service and these showed that there

was sufficient staff on duty to support people with their personal care needs. Daily records showed that personal care was provided in line with support plans.

Recruitment records were checked and although they showed that proper checks had been carried out on new staff before they stated work, we noted that some character references had been supplied by friends of applicants. We explained that best practice would be to obtain character references from previous employers, rather than friends. The Registered Manager noted this, and explained that this would be something the organisation would ensure took place in the future. Other employments checks included proof of identification and a criminal background check. Where there were any gaps in employment history an explanation had been sought so that there was a clear understanding of the person's experience. A fitness to work assessment was also completed prior to employment being offered. The checks in place meant that the provider could make sure that new staff were of suitable character and competence.

After discussion with the Registered manager regarding the usage of door wedges, we recommended that the service provider consult with the local fire service and housing provider regarding the best way to ensure that doors that are need to be kept open are done so safely. This is so that they can be closed either manually or automatically in the event of a fire. If action is needed following this consultation, we expect the Registered Manager to notify CQC of the action needed, and expect work to be carried out with a specific and appropriate timescale.

Good

Is the service effective?

Our findings

We spoke to four relatives about how effective they thought the service was. Again, the feedback was positive. One person said, "My relative has the best quality of life they have ever had. The staff are very proactive with them and encourage them do to things the thing that I would have liked to do, but couldn't when they lived with me." Staff spoke knowledgeably about the people they supported with personal care. They demonstrated a good understanding of how best to assist people who used the service in meaningful and effective ways.

Staff received the training they needed to support them in providing an effective service. Staff who were required to complete specialist training due to the needs of individual service users, had done so and there was a rolling programme of training renewal for all staff employed by the service. One staff member said, "If I have a suggestion for training or think of training that would be useful for me to support [Name] they put me on it".

We found that the Trust had started using the newly developed Care Certificate as an induction tool. Staff were expected to attend a five-day classroom based training session using this tool before then shadowing staff in the community when working with people. The induction process continued for 12 weeks, during which new starters were offered further training and support so as to ensure that they met the Care Certificate standards for health and social care workers and put them into practice in their daily working life. The Trust's chief executive spoke passionately about the use of the Care Certificate saying, "The introduction of the Care Certificate provides us with clear evidence that our staff have been trained to a specific set of standards and that they have been assessed for their skills, knowledge and behaviours. If people don't demonstrate they are putting our service values into practice, then we either offer them support and further training or, they don't complete their induction period." One member of staff talked about their induction which they were given when they first started. They described it as "quite intensive" and said it included training and shadowing other members of staff in order to become familiar with the people and their routines. They found this beneficial in learning about their role.

Specific training in behaviour management and understanding challenging behaviour was seen to be provided to staff who worked in specialist teams. These teams provided care and support to a small number of people who displayed challenging behaviours. The reasons for these behaviours were seen to be complex and related to people's assessed needs. For example, autism and historical factors, including previous placements. Staff explained that the training they were provided with "helped them understand the underlying reasons for why individuals challenge services" and "helped them develop strategies to ensure people were supported to live in a safe and secure place, designed around their needs and interests." When considering how to respond to challenging behaviour, staff explained that "behaviour management plans were in place that look at deescalating behaviours and concentrate on distraction techniques." We saw evidence of these. We were told of an individual who was supported by the service, who had previously lived in a long term institution. Prior to the move, they had displayed a lot of challenging behaviours, but since moving, these behaviours had reduced. Staff had been trained in how to work with this person before their move and, during the transition, had been able to spend time with the person, getting to know them.

Staff told us that they had supervision with a manager approximately every two months. This was an opportunity to discuss work issues in a confidential, one to one meeting. We saw that supervisions were recorded so that agreed actions could be reviewed. One member of staff told us, "Supervisions are more regular" and they felt that they were used positively to motivate staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005. 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 treatment when this is in their best interests and legally authorised under the MCA. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity.

We found that the service had appropriate processes in place to ensure that people were able to give consent to their support and care. Where people lacked capacity, the staff and manager knew how to comply with the MCA. Assessment and review processes were found to be in place to ensure that staff and relatives were kept up to date with a person's situation and to ensure that staff followed the correct procedures when supporting people who lacked capacity. We found documentary evidence to show that the systems operated within the service, relating to consent to care and treatment, took into account both local and national official guidance. Where needed, mental capacity assessments took place; best interest meetings were convened and referrals to the Court of Protection were made. Care and support plans were used to identify when a person was potentially at risk of having their liberty restricted. The staff we spoke with understood the need to ensure people were enabled to give consent to care and understood the requirement to seek external advice and guidance if there were any doubts about a person's ability to make informed decisions. The training records showed that staff had either received training in this area or were due to undertake such training.

People were supported to maintain good health. Each person had a 'Health Action Plan' which was written in an 'easy read' style with the use of pictures and large print. Again, these were found to be in the process of revision. Links between these and other plans, such as behaviour management plans, were being made so that staff understood people's health and social care needs more effectively. Plans contained clear and detailed information about each person's health needs and the support required. These had been written with the involvement of relevant professionals, such as a GP. Where a person required specific support with a health need, such as epilepsy, there were guidelines for staff about what to do if a seizure occurred. Records showed that people were supported to access relevant health professionals when needed.

As people lived in their own homes, meals times were flexible. Some people were seen to have meal planners as their health and social care needs required this. Others were seen to make choices about meals as and when they needed. People who needed support to drink and eat were seen to be provided with this in a sensitive and dignified manner. Staff were aware of the need to help people follow a balanced diet that promotes healthy eating. Some people had specific care plans relating to this. We saw evidence that the staff had been involved in identifying risks to people with complex needs in relation to their eating and drinking. These risks had been documented and clear action plans had been produced for staff to follow in order to minimise or eliminate those risks. Staff were aware of these plans and were able to talk about them in detail, showing a good understanding. If people needed access to dietary and nutritional specialists to help meet their assessed needs, then staff were seen to do this. Appointments were made when required,

and supported provided to attend. If specific information was supplied by this specialist, then this was recorded and incorporated into people's care plans.

Good

Is the service caring?

Our findings

We spoke to four relatives about how caring they thought the service was. The feedback was positive. One person said, "The staff are very kind. They know my relative very well, and do a lot for them. It's great to see my relative happy." We spent time with seven tenants in order to see how they were supported to live their lives in a safe and supportive environment. As the tenants did not all communicate verbally, we spent time observing their interaction with the staff and each other, and through concentrating on their body language and non-verbal cues, tried to get a sense of how they felt. How the tenants expressed themselves and moved around their home, gave us a sense of how they felt. We saw that tenants had positive relationships with the staff that supported them. They were seen to happily engage with staff, and were comfortable in their presence. Tenants were seen to approach staff, and direct them when wanting attention or support. Staff were seen to respond positively, and were happy to be directed by tenants.

Staff spoke about the people they supported positively and with regard for their wellbeing. All the staff we spoke with had a good awareness of each person's background, character, likes and dislikes and preferences. Whilst we did not observe any personal care being carried out, we did note that there was a familiarity and warmth between staff and the person they supported.

The Trust was found to use different approaches or styles of person centred planning tools when working with people. Each style was based on the same principles of person centred planning. All started with who the person is and ended with specific actions to be taken. They differed in the way in which information was gathered and whether emphasis was on the detail of day to day life, or on people's hopes, dreams and longer term plans for the future. Each planning style combined a number of elements: a series of questions for getting to understand the person and their situation; a particular process for engaging people, bringing their contributions together and making decisions; and in cases, the use of a facilitator to guide people through the process of planning for their care and support needs. Support plans contained useful information on each person's communication needs and how to involve them in making choices and decisions. People's preferences were also taken into account. For example, one person had particular routines that they liked to follow, and these were clearly outlined in the person's plan. Staff were seen to adhere to these routines in order to ensure that person was supported in a person centred manner.

A Service Guide was given to people and this contained easy to read information about people's rights, as well as how they could get support to be more involved in their care. The guide gave details of how the service undertook Person Centred Planning and there was also information about a local advocacy group, if people needed someone independent to speak on their behalf.

There were frequent references in support plans to the importance of promoting privacy and dignity. For example, one person's bathing support plan stated, "Staff must be mindful of dignity when supporting in the task and promote independence wherever possible". This was also highlighted in a section about applying skin cream which stated, "Complete in private to protect dignity". One staff member confirmed that they were very aware of the need to respect dignity when supporting with intimate personal care. They explained, "I tell [Name] what I am doing step by step so that they know what is happening."

Staff explained that they had received training in supporting people at the end of their lives. The service had systems in place that helped tenants to both think about and/or plan for the end of their lives. One staff member explained that due to some people's cognitive ability, discussing end of life issues was very difficult, as people's ability to understand the concept of death was limited. They added that "despite this, we have spent time thinking about the best way we would celebrate a person's life, and incorporated these elements into their care plans." We saw evidence of this. The registered manager explained that part of the person centred planning approach adopted by the service involved looking at death and dying. She said, "These tools all act as a guide to the staff to ensure that tenants can be offered choices regarding their care in the event of an illness or life limiting condition. If the person was unable to communicate their wishes or choices, then we would draw on information from their family and friends, and other professionals in order to ensure their best interests were met."

Good

Is the service responsive?

Our findings

We spoke to four relatives about how responsive they thought the service was. They told us that they had been involved in their relative's care planning, that the service kept them informed of how their relative was and sought feedback from them as and when required. One relative expressed dissatisfaction over a recent incident when their relative had experienced an injury after a fall. This issue was looked into by the management of the service and a full explanation given as to why the incident had not been recorded correctly. The staff member, who should have recorded the incident, left the employment of the service the day after the incident and in doing so had failed to follow the Trust's procedures. The management investigation found that although the fall had been logged, the injury to the person had not. The Trust has since put a new management structure and reporting systems in place regarding incidents such as this and liaised with the family to ensure that they were satisfied with their response. The family are now satisfied with the systems in place and their hope is that incidents like this will not occur in the future.

Following a recent investigation into alleged financial abuse at one of the tenancies, the Trust introduced a new, more robust financial recording system. All transactions are recorded on a computer database by staff following an activity, for example, shopping. This entry is then automatically removed from view, so that only the running total can be seen. This is so that staff cannot make any changes to transaction figures once they are on the database. The running total is the amount that should be in a person's money tin. Managers from the Trust then audit tenant's finances on a monthly basis to ensure that both the running amount and actually quantities in the tins reconcile. Staff must provide receipts for all transitions and all transactions are recorded on a separate written financial record. These records are then used during the audit process.

People had up to date support plans which gave clear information about individual needs. Information was personalised and explained in detail how to support people with their personal care. Support plans were regularly reviewed and some were in the process of being completely reviewed in order to ensure all the most relevant and up to date information was easily accessible and useable by the staff team. The manager explained that, because people were not easily able to communicate their needs, the views of others had been sought in order to get a good overview of each person's preferences, interests and abilities. This included the views of relatives and other professionals such as a GP or social worker.

We saw written evidence to show that people were supported to contribute to their care plans through the use of recognised person centred planning techniques and tools. These tools and approaches were seen to take into account people's views about their strengths, levels of independence, health and what their quality of life should be. If they were unable to put forward views such as these, facilitators were seen to help draw on information from other people in the individual's life such as family, friends, and other professionals. The support plans were found to reflect how people would like to receive their care. This was seen to include their personal history, individual preferences, interests, aspirations, and made sure they had as much choice and control as possible. People were seen to follow their interests, take part in social activities and, where appropriate, education and work opportunities. People were seen to be encouraged and supported to develop and maintain relationships with people that matter to them which helped to avoid social isolation.

The registered manager explained that when people moved between services, for example from child to adult services or placement to placement, this was done in an organised way. We saw that a manager was given the responsibility to oversee the transition and support the person and their family, if needed, through the change. A documented transition plan was put together based on the individuals assessed needs and relevant professionals were kept informed throughout the process. Training and advice was seen to be given to staff and to the individual, if required, to prepare them and their family for the transition. If consent was required, then advocacy and best interests meetings were seen to have taken place.

There was an up to date complaints procedure in place which gave clear guidelines on making a complaint about the service, as well as contact details of other relevant organisations such as the CQC and the Local Government Ombudsman (LGO). The LGO is an organisation that can get involved when the local authority complaints procedure has not provided a satisfactory response. There was an easy read version of the complaints form for people who used the service. Although we were unable to get confirmation from people, the registered manager told us that people were often reminded of their right to complain. Complaints received had been recorded and there was a clear record of the action taken.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. The registered manager and service managers spoke enthusiastically about their roles and the development of the service. They said the aim of the service was to promote a person centred, outcome focused culture within the team and the people they supported.

The registered manager explained that they tried to promote an open culture in the service through regular team meetings and staff supervisions. Staff meeting minutes were found to cover all aspects of service delivery. Discussions took place regarding incidents and how the service could be continually improved in the light of lessons learnt from incidents. Managers explained that there was an 'open door' policy for staff to approach management at any time. Staff gave positive responses when asked about the management of the service. One staff member said there was good communication and that they were able to approach managers at any time.

The Trust had an effective quality assurance system in place. This was structured on four different quality assurance tools produced by external partner organisations. The tools were, "Driving Up Quality", "The Learning Disabilities Health Charter for Social Care Providers, "Think Local Act Personal (Making It Real)" and "the Lancashire Values". These tools were used by the management team to undertake audits and checks through self-assessment, stakeholder feedback and data management on service quality issues, people's health care needs, how personalised the service was and how people's rights were promoted and protected.

After consultation with people supported by the service, their families, commissioners, staff, and trustees, an action plan was produced by the Trusts' chief executive. People's involvement and feedback was seen to be central in the creation of this document. Action points that had been identified as needed to improve the service included a change to the end of life and "When I Die" document to reflect the approach taken with Ormerod's Person Centred Planning (PCP) toolkit. Improve to communication within the service would take place, as a member of management staff would be assigned to a service user's family to act as a 'one stop shop' for information and advice. Other action points had been identified through this process and measures were in place to ensure the service undertook the work needed through the assignment of staff to particular roles, the liaison of the service with external agencies and revision of some ways of working. The action plan produced by the Trust was shared with trustees and was published on the Trust's website. The chief executive officer explained that publishing the document on line and sharing it others was important as it showed that the Trust was open about where it needed to make improvements and it allowed for the organisation to be scrutinised and held to account.

The service had an open and transparent culture, with clear values and vision for the future. It was clear that staff shared this commitment and vision and they were supported through training and clear leadership from the registered manager and management team, to provide this for the people who used the service. The service worked in partnership with key organisations including specialist health and social care professionals.

People were involved in decisions about the service. For example, service user forums took place on a regular basis where people were encouraged to put forward their views on the service and influence decisions about activities and events. We spoke to an external professional who visited a person supported by the Trust who told us, "The different teams have a very demanding role. The service is always well organised. They have a good training system in place and a clear understanding of my client." Staff told us they were able to raise any issues or concerns with the registered manager or service managers. They felt they were always listened and responded to. Staff were happy and worked well together ensuring a consistent, calm and positive atmosphere, which was reflected in people's care. We confirmed the registered provider had sent appropriate notifications to CQC in accordance with regulations.