Aspirations Care Limited

Aspirations Northwest Adults

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection of Aspirations Northwest Adults took place on 18 & 19 April 2016.

There was a new manager in post who had yet to apply for the position of registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run'.

Aspirations Northwest Adults is a domiciliary care service providing 24 hour care, mostly within a supported living setting. The service supports people with complex mental health needs or learning disabilities.

People were administered their medicines by staff who were trained in the safe administration of medicines. We found however the medicine policy was unclear, there was a lack of information around the administration of 'as required' (PRN) medicines and staff competencies to administer medicines were not always checked.

We have made a recommendation around improving the safe management of medicines.

People said they felt safe when supported by the staff in their home.

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. A safeguarding policy was in place for staff to refer to along with local authority guidelines for reporting an alleged incident.

Staff sought advice and support from external health professionals when needed to help assure people's health and wellbeing.

Risk assessments were in place to ensure people's health and safety. The risk assessments helped to help mitigate those risks and to protect people from unnecessary harm.

People had a plan of care/support plan which recorded their needs, wishes, preferences and medical history. The support plans identified the level of support people needed to maintain their health and wellbeing. Healthy eating was promoted by the staff and nutritional support given as required.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). A number of documents showed people's consent, or relatives' consent (if legally empowered to do so) to evidence their inclusion in the planning of care.

People were supported by sufficient numbers of staff to provide care and support in accordance with

individual need.

Recruitment procedures were robust to ensure staff were suitable to work with vulnerable people. Staff files reviewed showed all relevant recruitment checks had been undertaken prior to staff starting work at the service.

Sufficient numbers of staff were available to support people in their own home. This was confirmed by talking with staff, looking at staff rotas and talking with people who used the service and their relatives.

Staff told us they were supported through induction, on-going training, supervision and appraisal. Formal supervision meetings had not been held recently for a number of staff. Following the inspection the acting manager confirmed these were being undertaken. A training plan was in place to evidence staff learning and development.

We visited some people in their own home. We saw staff speak in a gentle and caring manner. Staff took time to listen and to respond in a way that people engaged with understood. Our observations showed staff had a good understanding of the people they supported. Staff told us how they respected people's day to day choices and they were aware of promoting good standards of dignity and respect in their work.

Maintenance and safety checks for fire safety were undertaken in people's own home.

A process was in place for managing complaints. People we spoke with knew how to raise a concern or make a complaint. The complaints procedure along with a number of other policies were available in an easy read format to help people's understanding.

We received positive feedback about the management of the service from people who used the service, relatives and staff.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the service. This included the provision of questionnaires and meetings. The acting manager informed us questionnaires were due to be sent shortly, as it was acknowledged this type of feedback had not been sought for some time.

Quality assurance systems and processes were in place. These were not as robust as they could be in light of our findings and also the findings from a recent service report which identified actions required in a number of areas.

We have made a recommendation around improving the current auditing systems and processes to assure the service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were administered their medicines by staff who were trained in the safe administration of medicines. We found however the medicine policy was unclear, there was a lack of information around the administration of 'as required' (PRN) medicines and staff competencies to administer medicines were not always checked.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Measures were in place to regularly check the safety of people's homes.

Risk assessments were in place to ensure people's health and safety. The risk assessments helped to help mitigate those risks and to protect them from unnecessary harm.

Recruitment procedures were robust to ensure staff were suitable to work with vulnerable people.

Sufficient number of staff were employed to offer support in accordance with people's individual need.

Is the service effective?

Good

The service was effective.

Staff sought advice and support from external health professionals when needed to help assure people's health and wellbeing.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). A number of documents showed people's consent, or relatives' consent (if legally empowered to do so) to evidence their inclusion in the planning of care.

People's nutritional needs were monitored by the staff and healthy eating was promoted.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal. A training plan was in place to evidence staff learning and development.

Is the service caring?

Good

The service was caring.

Staff support was given in a respectful and caring manner. Staff took time to listen and to respond in a way that people they engaged with understood.

Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences. This helped to ensure people's comfort and wellbeing.

Staff told us how they respected people's day to day choices and they were aware of promoting good standards of dignity and respect in their work.

Is the service responsive?

Good

The service was responsive.

Staff we spoke with had a good understanding of people's needs and how people wish to be supported.

People's care was planned effectively to ensure they received the care and support they needed. Care plan/support plans were in place for staff to follow.

People who used the service and relatives told us they were involved with the plan of care.

A process was in place for managing complaints. People we spoke with knew how to raise a concern or make a complaint.

Arrangements were in place to seek the opinions of people and their relatives, so they could share their views and provide feedback about the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager in post. The new manager had yet to apply for the position of registered manager.

There was a management structure in place which helped to promote the on-going development of the service. Staff provided positive feedback about the acting manager and the changes being made to improve the overall management of the service.

Staff were aware of the home's whistle blowing policy and said they would not hesitate to use it.

We saw a number of quality assurance systems and audits were in place to monitor performance and to drive continuous improvement. Our findings and those of senior management within the organisation highlighted the need for actions in a number of areas. The existing auditing systems were not as robust as they could be to assure the service provision.

Aspirations Northwest Adults

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 announced inspection took place on 18 & 19 April 2016. 'The provider was given 48 hours' notice because the location provides a domiciliary care service to people who are often out during the day; we needed to be sure that someone would be in'.

The inspection team consisted of two adult social care inspectors.

The provider submitted a Provider Information Return (PIR) prior to the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we reviewed the information we held about the agency. We looked at notifications and other information the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with four people who used the services of the agency. We spoke with the acting manager, a regional manager, a training facilitator, a training manager, a deputy manager, a placement manager and four care staff/support workers. We spoke with five relatives and two health care professionals as part of our visit. The interviews with relatives, external health care professionals and staff were conducted by telephone and in person.

We viewed a range of records including, care documents for four people who used the service, four staff personnel files, medicine records, records relating the running of the service and a number of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Staff were providing care and support to people mainly in a supported living setting. The service supported people with complex mental health needs or learning disabilities.

We sought people's permission to visit them in their own home. People who used the service told us they felt safe in their home when the staff were there. People reported, "Staff are always nice to me. They talk to me in a nice way", I'm safe. If I didn't feel safe I'd tell the staff. There is always enough staff", "Yes, I feel safe" and "My staff make me feel 100% safe even when I'm outside in the dark." Relatives told us they had no concerns around safety and they could speak with the staff if their family member did not feel safe. They also told us there were enough staff to support people safely and that the correct staff ratio was adhered to.

The acting manager informed us they had sufficient numbers of staff to provide care and support to people in their own home. They advised the staffing numbers were adjusted to meet people's needs. People who received care and support from the service told us the staff were on time. The acting manager told us they monitored the time staff arrived and left people's homes through their quality checks.

We saw the staffing rotas for the last four weeks and these provided the names of staff and hours worked. We saw people were supported by the same small staff teams to help ensure consistency of care. Staff we spoke with told us the small staff teams worked well and this view was supported by the people they cared for and health care professionals we spoke with. When discussing people's care, staff reported, "We keep people safe by supporting and guiding them" and "We keep people safe by having security measure and providing 1:1 support. I'm involved in all reviews to make sure things stay safe."

Staff told us there was an 'on call' system for 'out of hours' cover. This system ensured a senior member of the staff team was available should their support be required. We were shown an 'on call' file and a senior member of the staff team told us this provided essential information around being 'on call' and other relevant documents, for example, a safeguarding flow chart. A staff member said, "I can contact the managers or ask them to call-in at any time. We also have the on-call service and team meetings."

The service had systems in place to protect people from abuse. The acting manager was aware of their role in reporting allegations of abuse to the relevant agencies, for example, local safeguarding teams. They showed us safeguarding referrals made and some safeguarding referrals referred to the local authority had resulted in required actions. These had been acted upon promptly to ensure good practice and to protect people they supported. We spoke with staff about safeguarding and steps they would take if they were concerned about somebody; the staff gave appropriate responses.

A safeguarding policy was in place along with local area safeguarding procedures for staff to follow; safeguarding information was also in an easy read format to help people's understanding. The acting manager told us details about all local area safeguarding procedures would be placed in the 'on call' file for staff to refer to as not all this information was present. The staff training plan evidenced training in safeguarding adults which was given to all staff. A staff member said, I've done my safeguarding training and

I'd know what to look out for and what to do."

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

We looked at how the service supported people who required support with their medicines.

Staff told us they had received medicine training and this provided them with the skills and knowledge to support people with their medicines. When talking to staff about medicines they told us, "I have the right training every 12 months" and "When I started I did medicine training with the company trainer. I have just renewed it. I feel confident to administer medication." People who needed support with their medicines told us they received this. A person said, "I take my tablets every day. Staff help me. I always have my tablets."

We looked at four medicine charts and these recorded staff signatures for medicines administered. There was however no record of staff initials for comparison purposes. Medicines were checked for stock balances along with significant issues at staff handovers. The spot checks on stock levels we completed at random were found to be correct.

Staff training records showed staff had attended medicine training. We did not see any checks on staff's competencies to ensure they were administering medicines safely to people in their own home as part of assuring safe medicine practice.

We looked at the agency's medicine policy and procedure and this recorded staff offered support and assistance with medicines. Staff however told us they administered medicines and therefore the policy was not clear for staff to follow. 'As required' (PRN) protocols were in place though we found these were also not always clear or sufficiently detailed. For example, for one person there was not instruction regarding the point at which the person's PRN medicine needed to be given and for another, their PRN medicine was written up to be given four times a day. Discussions with staff however confirmed their knowledge regarding when to give these medicines and the service's PRN protocol included contacting a senior member of staff for advice regarding the administration of RRN medicines. A staff member told us, "If (person receiving their medicines) needs (medicine) you assess the situation and phone the on-call."

The acting manager was informed of our findings and they told us they would take action to improve the safe management of medicines.

We recommend that the service consider current guidance on the safe management of medicines and take action to update their practice accordingly.

Risks to people' safety had been assessed as part of their plan of care. The risk assessments helped to mitigate those risks and to protect people from unnecessary harm. The care files we looked at showed staff had completed risk assessments in areas such as, mobility, social isolation, behaviours, food, drink and hygiene.

Staff were providing support for people in a 'supported living' setting therefore maintenance of people's homes was monitored to ensure people lived in a comfortable and safe environment. The acting manager confirmed dates for pending maintenance work which had been previously identified by the staff and by us

during the inspection. A personal emergency evacuation plan (often referred to as a PEEP) had been completed for the people we visited.

Incidents that affected people's safety were documented along with the actions taken following the incident and we saw evidence of the reporting system to head office. The acting manager told us incidents were tracked through to identify themes and reduce the risk of re-occurrence. This helps to people's on-going safety and wellbeing. Staff said they would report any accident or incident or concerns about people's safety to their manager and that they got feedback regarding subsequent actions.

Lone working for staff was risk assessed and the acting manager informed us all staff were being issued with a work phone in case of emergencies.

Protective clothing, such as gloves and aprons were available for staff if required.

Good

Is the service effective?

Our findings

People who used the service told us they were happy with the care and support they received. Relatives told us the staff provided support and people were able to decide how they wished to spend their day. They also told us their family member benefited from receiving care from the same staff team and having access to a range of visiting health professionals.

Care documents provided information about people's medical conditions and the service liaised with external health and social care professionals to support people or if their health or support needs changed. An external health care professional told us the agency staff were good at monitoring a person's needs and their 'general' welfare and that that the person they visited had 'come on leaps and bounds' with the current staff intervention. A person told us about the health reviews they attended and how they were accompanied by staff. Staff told us they worked closely with external health professionals and this was evidenced in the care records we saw. One staff member told us about they accompanied a person for regular checks as part of monitoring a medical condition. They told us about the care and support this person received so that their condition was well controlled. Another staff member told us about the effectiveness of a person's plan of care and the good outcome achieved for them.

We met with the service's training facilitator and looked at staff training. The training facilitator oversaw the induction for new staff and the service's training programme. A manager was responsible for the delivery of positive behaviour management training (PBM).

The induction included a three day shadowing period for new staff, as they became familiar with the service and the needs of people they supported. An induction book/portfolio included a number of areas, for example, information about the organisation, the role they were undertaking, mental capacity and health and safety in an adult social care setting. Information relevant to the supported living setting they would be working in was also included and the induction was aligned with the care certificate standards. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. We saw a separate induction for managers in accordance with their job role.

The training plan evidenced courses attended by the staff and certificates were available in staff files. The training programme was relevant to the needs of the people using the service and more specific training was given to meet people's complex needs if required. Training for staff included, moving and handling, health and safety general principles, nutrition, fire safety, infection control, self-harm, dementia, food safety, positive behaviour management training, mental capacity, Deprivation of Liberty Safeguards (DoLS) and safeguarding adults. Training percentages were over 98% for courses completed by staff. Staff reported the training facilitator arranged training courses and refresher training on a regular basis. Their comments included, "I've done PBM training and refreshers. I spot early signs and try to stop things escalating" and "We get mandatory training every twelve months and supervision and appraisal."

Formal training in NVQ (National Vocational Qualifications) in Care/Diploma had also been obtained by approximately 80% of staff as part of their learning and development.

Staff were issued with a training contract which stated, 'Aspiration strongly believes in training its staff to the highest degree ensuring a service of excellence for our service users.' Our findings helped to evidence the service had a strong commitment to learning.

Staff we spoke with confirmed they received supervision and an appraisal each year. We did however see gaps where staff had not received formal supervision for lengthy periods of time. We brought this to the acting manager's attention who was aware that these meetings and also appraisals needed to be conducted. Following the inspection we were informed that the majority of staff had now attended formal supervision with their line manager and appraisals were underway. Currently supervision meetings were held once a quarter. We discussed with the acting the manager whether the frequency of these meetings should be increased though staff told us they felt fully supported by their line manager.

We saw minutes of staff meetings which were held at in people's homes where they were supporting them to live independently. These meetings tended to focus more around people's needs; we talked with the acting manager about extending the agenda to include more staff related issues and organisational updates. Staff told us the staff meetings were a good way of sharing information about the people they supported.

At this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use and how someone may be deprived of their liberty. We saw that MCA training was given to managers and staff.

We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions staff told us about decisions that had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. We discussed with the acting manager ways of better recording these meetings as it was not always possible to see who had been involved or how this decision had been reached. An example of this was for a person who required specific support for clinical observations and pending hospital treatment.

Staff had obtained people's consent around areas such as, having their photograph taken and for staff to administer their medicines. People who used the service were asked to consent to care and support and some people had signed to say they were in agreement with their plan of care. Staff told us they asked for people's consent before assisting them. They said emphasis was placed on providing individual assistance and maintaining and promoting people's independence. Staff told us how they worked closely with people and involved them in day to day decisions and choices. For example, accessing community based events, choosing meals and being encouraged with daily household tasks.

We talked with staff about communication and they told us the importance of body language, tone of voice and use of words that need to be considered when talking with the people they supported. They told us that having consistent small teams enabled the staff to know people well and develop positive working relations.

Staff provided support with meals in accordance with people's needs. People told us, "I go shopping for food. I get to choose. The staff make the food for me" and "Staff do a shopping list with me. They know what

food I like". Staff were aware of the need to promote healthy eating and to report any concerns if a person had a poor appetite.

Good

Is the service caring?

Our findings

People told us the staff were kind, a person said, "The staff are always nice to me, they talk to me in a nice way." Another person reported, "The staff are very good. I get to see the manager a lot." When discussing staff support relatives told us, "The support has given (people who used the service) a quality of life that they've never had before. This support has opened doors for them. Staff are definitely supportive", "I trust the staff implicitly", "They treat (people who use the service) with the utmost respect" and "They (staff) respect privacy. It's like a big family."

We spent a short time with people in their own home and we observed positive interaction between the staff and the people they supported. We saw staff speaking in a gentle and caring manner and allowing a person to take the lead as we were shown round their home. Staff took time to listen and to respond in a way that people they engaged with understood. Our observations showed staff had a good understanding of the people they supported. There was a relaxed atmosphere in people's homes.

Staff told us how they respected people's day to day choices and they were aware of promoting good standards of dignity and respect in their work.

People received care, as much as possible, from a consistent staff team. This meant people had the opportunity to build relationships with staff and that staff had the opportunity to get to know the people they supported well. A staff member gave us an example of organising a shift change so they could be with a person (who they usually looked after) who required medical attention thus reducing their anxiety and the risk of an incident. The training facilitator told us staff's skills, knowledge and expertise were matched in accordance with people's needs. This was to make sure people received the required support from experienced staff.

Through conversation it was clear staff had a good understanding of people's individual needs and preferences. Staff told us they had access to care documents which provided information about the support people needed, the support they wished to receive and their current needs. This enabled people to receive person centred care; people received care and support tailored to their individual need. We saw some evidence of people being involved in their plan of care from the assessment to care planning stage.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so with or without staff support.

A 'service user guide' provided information about the service. An easy read format was also available and the acting manager told us about the changes they were making to the document so it would contain more 'relevant/local' information in respect of the service.

People's care records were kept in people's homes and staff were aware of the need for maintaining confidentiality.

Good

Is the service responsive?

Our findings

Where possible people had been involved with their plan of care. People told us, "I get to talk about my care every six months" and "Staff ask me about any changes that I want to make." Another person told us their family were involved as well as the staff to support them. A relative said, "We're involved in any changes to care plans. We're included in everything." When discussing how staff responded to the people a relative told us how well the staff picked up on non- verbal signs as they knew how their family member communicated.

We looked at the social aspect of people's support. We saw evidence of staff responding to people's individual wishes as to their involvement with their chosen hobbies, daily tasks and activities. People told us the staff helped them achieve these. People told us they went out with the staff and their families and made reference to the actions undertaken by the staff to make their home 'homely' in appearance. A people told us, "Staff encourage me to be more independent with my cooking. I go shopping and I go to town to buy clothes." A relative told us about the social activities their family member took part in. They told us, "Nothing is too much for them (staff)." One relative fed back their family member could go out more with the staff.

Care plans recorded information about the person and their care and support. This information had been obtained by talking with the person concerned, their family and external health care professionals. Care/support plans were written so they encouraged people to be independent, to exercise choice and also to receive the support needed to maintain their health and wellbeing. We saw for example, in respect of medicines, a booklet which outlined the information people needed to make choices around taking their medication. Health care plans were in place for monitoring people's health and wellbeing. Staff discussed with us the care and support for a person with complex medical needs and the input from health care professionals. It was evident the staff member knew the person well. A staff member said, "I'm really passionate about the job. I always want people to do better."

We saw information around how staff responded and supported people who had a learning disability with a behaviour that may challenge. This information was recorded using a positive behaviour support plan. These plans have strategies in place to support the person by reducing the behaviours that may challenge and increase the quality of life for the person. Staff were able to give examples of these plans, how a person's quality of life had improved and how they were now 'moving on'. An external health professional who was involved with this transition was complimentary regarding staff involvement.

People's care was subject to review with them and their relatives where legally empowered to do so. Staff comments included, "Regarding reviews of care planning – I think we're the most important people to ask because we're with people all the time. If we see a change we report it straight to the manager" and "We keep people safe by having security measures and providing 1:1 support. I'm involved in all reviews to make sure things stay safe."

Staff we spoke with told us they were informed of any changes in people's care needs. This was achieved through staff handovers and on-going discussions about people's care needs. Staff had a good knowledge of people's preferences and how to support each person in a way that they liked. Talking with staff

confirmed how they responded if people were unwell or there was a change in their needs.

Information about how to contact the agency out of normal working hours was made available to people who used the service. Staff told us what actions they would take in an emergency and this involved always reporting an incident to senior staff on call.

The provider had a complaints' procedure which was also available in easy read format to help people's understanding. We reviewed a complaint received and saw this had been investigated and responded to in accordance with the agency's complaints' procedure. A person told us if they were treated unfairly they would speak up. When discussing the complaints' procedure with relatives, we received the following comment, "I'd go straight to the management if there were any issues or I'd go to CQC. I feel that I've got a good rapport with the managers and any complaint would be dealt with." A relative raised some concerns with us and we have subsequently followed this with a call to the acting manager so that the areas of concern could be discussed further.

A process was in place to seek feedback from people who used the service, relatives and staff. This was in the form of a questionnaire. The acting manager informed us these were due to be sent out shortly and this was confirmed in the provider information return (PIR). The PIR told us the survey enabled the service 'to ask and consult whether people feels safe, ensure they know what to do and who can help them and inform further local strategy to involve the people we support, in work around keeping safe'.

People also told us they could express their views about the service through meetings which were held for them and their families/representatives. A relative told us, "I get feedback for my opinions and they always keep me informed if there's a problem." We saw minutes of meetings held.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager in post. The acting manager advised us they would be applying for the position of registered manager for Aspirations Northwest Adults.

Staff provided positive feedback about the acting manager and the changes being made to improve the overall management of the service. Staff provided the following comments, "Managers involve us all the time", "I just love my job. It gives me a great sense of pride", "A good management structure is now in place, and this change was needed."

The management structure included an acting manager, service managers, deputy managers, a placement manager, training facilitator, training manager and a regional manager. There were clear lines of accountability and talking with the managers showed they understood their responsibilities. They in turn were supported by the Operational Director and The Head of Quality. The PIR told us about workshops with managers to provide training around quality assurance and quality initiatives to drive forward compliance and development of the service.

Staff told us the service had an open and transparent culture. Staff were aware of the whistle blowing process and told us they would use it to report any concerns or poor practice. They told us they had confidence senior management would take their concerns seriously. The PIR provided information about 'Safecall' which gives staff and service users the opportunity to whistle blow or just simply highlight less serious issues that none the less may be important to them and that they feel are not being resolved at a local level'. Details about 'Safecall' were available in the 'on call' folder for staff to refer to.

Various approaches were in place to seek feedback about the service from people and their relatives to include them in service developments. This included 'house' meetings for people in a supported living setting and care reviews with them and their relatives. In March 2016 the acting manager and a regional manager also met with staff as a general form of introduction in their role, to get feedback regarding how the 'houses' for supported living were operating and to discuss staff training. Weekly managers meetings were held at the office and minutes from a meeting in March 2016 were available with an action plan.

At this inspection we looked at quality assurance systems, including audits (checks) to monitor performance and drive improvements. Audits were completed for each 'house' as a supported living setting. We looked at two audits for two 'houses' completed in April 2016. This included area such as, staffing, environment, accident/incident reporting, safeguarding, medicines, and support plans. This information was collated into a manager's monthly report, along with other reportable events and a quality assurance report presented to the senior management team and Board of Directors. The acting manager was able to confirm the completion of work needed to improve people's accommodation.

In February 2016 the Head of Quality for the organisation completed a full service audit. This was an additional higher level of monitoring to check the quality and safety of the service. The service audit picked up on a number of areas that required improvement. For example, some support plans lacked clarity and

detail in key areas, missing recruitment checks and concerns around reporting safeguarded incidents. The acting manager informed us that actions plans were being drawn up to meet the requirements of the service audit and these were due on 22 April 2016. The acting manager informed us these action plans would include timescales for completion of the actions. The service audit did not record any timescales for staff to follow.

In light of the findings from the full service audit the service's internal auditing system needs to be reviewed to ensure it is 'fit' for purpose' and robust. This need to include the areas we have identified in our inspection. For example, the current medicine audits lacked detail and had not picked up on the areas we found. We discussed with the acting manager on how to improve the quality of the audit to assure the safe management of medicines.

We recommend the service reviews its quality assurance processes and systems to help ensure people receive a safe, effective and well led service.

In respect of driving forward the service the acting manager shared with us a new initiative to encourage people to take a greater part in how the service operated. This was for people to be part of the recruitment process for new staff. The Head of Quality also informed us of further accredited training for working with different client groups, training more trainers and the appointment of an autism lead for the organisation.

The acting manager on their appointment found that we had not been notified of a number of events which we should have been informed of. For example, statutory notices regarding abuse or allegation of abuse concerning a person who uses the service. The acting manager has since sent us the statutory notifications regarding these events and has submitted notifications in a timely manner for incidents that have occurred since their appointment. Discussion with the acting manager confirmed their knowledge about the events that require a statutory notification.