Robelen Enterprises Ltd

Aspire Community Care & Support

Inspection report

St Mark's Centre
218 Tollgate Road
London
E6 5YA

Tel: 02070553880
Website: www.aspire-support.com

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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

About the service:
• Aspire Community Care & Support is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to the whole population. Not everyone using Aspire Community Care & Support receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.
• The provider had one domiciliary care agency within their registration.
• At the time of the inspection it was providing a service to six people.

People's experience of using this service:
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was safe.
• People's risks were assessed and strategies put in place to reduce the risks.
• People's likes, preferences and dislikes were assessed and care packages met people's desired expectations.
• People and their relatives provided positive feedback about the care, staff and management. They said the service was caring, timely, effective and well-led.
•People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
• People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People and their relatives were involved in the care planning and review of their care.
• The service had a stable management structure. The provider had implemented systems to ensure they continuously measured the safety of people's care and quality of the service.

Rating at last inspection:
• Requires Improvement (report published on 18 January 2018)

Why we inspected:
• All services rated "requires improvement" are re-inspected within one year of our prior inspection.
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
• We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 was safe. Details are in our Safe findings below.	Good
Is the service effective? The service was effective. Details are in our Effective findings below.	Good
Is the service caring? The service was caring. Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led. Details are in our Well-led findings below.	Good

Aspire Community Care & Support

Detailed findings

Background to this inspection

The inspection:
• We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
• The inspection team consisted of one inspector.

Service and service type:
• Aspire Community Care & Support is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community.
• The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
• Our inspection was announced.
• The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.
• Our inspection process commenced on 5 March 2019 and concluded on 5 March 2019. It included visiting the service's office and telephoning people who used the service and their relatives. We visited the office location on 5 March 2019 to see the registered manager and office staff, and to review care records and policies and procedures.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback

we received from members of the public and the local authority. We checked records held by Companies House.

• The provider had completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

• We spoke with one person who used the service and two relatives.

• We spoke with the registered manager, the care supervisor, the care coordinator and three care workers.

• We reviewed three people's care records, three staff personnel files, staff training documents, and other records about the management of the service.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

At our last inspection on 5 December 2017, this key question was rated "requires improvement". We found the provider did not have enough staff employed to ensure people's needs were met and measures were not always in place to reduce risks for people. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the provider had taken steps to improve the safety of people's care. Therefore, the rating has changed to "good".

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management:
• People had risk assessments in place and these were detailed. Each person had an environmental risk assessment as well as individualised risk assessments relevant to each of their needs. Risks covered included communication, washing and dressing, toileting, eating and drinking, pressure sore care, social and recreational, moving and handling, pain, sleep, environment, behaviours that challenge, self-harm, self-neglect, diabetes and medicines.
• For example, one person had been assessed of having behaviours that challenged. The risk assessment stated, "[Person's] mood can change very quickly usually when she is upset about something [like] being woken too early or if the carer is new and she doesn't like them. Allow her space for about 5 to 10 minutes to calm down. If the behaviour has stopped and it appears she has calmed down, go back to her and gently ask if she would like you to come and assist her. Follow this up with a conversation about something she likes talking about." We spoke to the staff member who cared for this person. They told us, "[Person] has a big temper. I will sit next to her and ask who has upset her. I can calm her down to a level. When I know she is throwing things [I] will back off and leave her for 10 minutes." This showed staff understood risks to people they supported.
• Staff we spoke with were aware of people's risks and knew how to support people in a safe way, whilst maintaining their freedom. One staff member said, "I would speak to [registered manager] or the office if something wasn't right [with the person]. They would go and see [person]." This showed staff met people's needs safely.

Staffing and recruitment:
• Through our discussions with the registered manager, staff, people and their relatives, we found there were enough staff to meet the needs of people who used the service.
• Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. The registered manager told us he had introduced a team of care workers for each person using the service. The team of care workers would cover the shifts for the person which included unexpected absences and annual leave. The registered manager said, "We have a team of carers for each [person] and keep that regular. When a carer goes on a holiday, [we] get one of [the other] carers in the team to cover. We have enough carers to cover now."

• One person told us, "Yes, [staff] come on time. [If a] couple of minutes but they will call and let me know." The same person commented, "[Staff] take their time. They don't rush." One relative said, "They have enough staff. It is always covered. They are never late. Always on time. Very good timekeepers." Another relative told us, "[Staff] come at the right time. They have been late a couple of times but that was a year ago. [Registered manager] dealt with that."
• Staff told us there were sufficient staffing levels and their shifts were covered when they were on sick and annual leave. One staff member told us, "[Provider] will give me at least half an hour to next [person to visit]. That's enough time. Far as I know [enough staff]. Always someone to cover. I went away for a weekend and someone covered me." Another staff member said, "We cover each other. Work with a [person] with three carers. If [staff member] can't do [shift] I jump in. When we book our holidays, we make sure we are both not off. It is team work."
• The provider followed safe recruitment practices.
• Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. One staff member said, "[Provider] did DBS before I started even though I had one. They said they had to their own."

• People and their relatives told us they felt the service was safe. One person told us, "Yes, [safe] because how [staff] work. They are very good." One relative said, "Yes, 100 percent [safe]."

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risks of harm, abuse and discrimination.
• There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
• Staff and management we spoke with had a good understanding of their responsibilities. One member of staff said, "I would call straight away to the manager to report and I would record." Another staff member said, "First, I would speak to the manager. If still going on, and [registered manager] did nothing I would go to police and social services. I have to blow the whistle."
• Staff completed safeguarding training to provide them with knowledge of abuse and neglect.
• The registered manager was able to describe the actions they had taken when incidents had occurred which included reporting to the Care Quality Commission and the local authority. The registered manager said, "We give staff a lot of confidence to support them with whistle blowing. We talk about it in supervision and meetings. They can go to the local authority. It is their right. People shouldn't be left to suffer because of our negligence."

Using medicines safely:
• People's medicines were administered safely.
• The service had a medicines policy in place which covered the recording and administration of medicines.
• Records showed staff were up to date with medicines training.
• Medicine competency checks of staff were undertaken. This ensured they remained safe to continue to administer medicines.
• People who were supported with medicines had a medication administration record (MAR). We found these were accurately completed and showed that people received their medicines as prescribed.
• MAR records were returned to the office monthly and checked.

Preventing and controlling infection:
• Staff completed training in infection prevention and control on a regular basis. Records confirmed this.
• Staff had access to personal protective equipment such as gloves and aprons. One staff member told us, "Firstly, you wash your hands. Make sure [you] don't mix raw and cooked food. We have got gloves, shoe

covers and aprons."
• Staff completed training in food hygiene, so that they could safely make and serve meals and clean up after preparation.

Learning lessons when things go wrong:
• There were systems in place to learn lessons when things went wrong and make improvements.
• There had not been any incidents since the service's last inspection.
• Systems were in place to share lessons learnt with incidents in team meetings and supervision sessions.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

• One person told us, "[Staff] can't be better because they look after me very well." One relative said, "[Staff] are very good."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The service aimed to obtain as much information about a person before a new care package commenced. Before admission to the service a needs assessment was undertaken to assess whether the service could meet the person's needs. This included assessments from commissioning bodies, and feedback from people and their relatives. One relative told us, "Yes they did [needs assessment]. They talked to [relative] and me."
• Staff knew people's preferences, likes and dislikes. Information available included meal choices, and personal hygiene routines.

Staff support: induction, training, skills and experience:
• When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. One staff member said, "Induction was everything about the company and the job. They shadowed me everywhere I went. I was shadowed by the carer who had already been going [to person]."
• Training was provided in subjects including safeguarding adults, diversity and equality, fire training, moving and handling, infection control, medicines, The Mental Capacity Act 2005, food hygiene, health and safety, nutrition and diet, and first aid awareness. Staff also received training specific to the people they were supporting. These included challenging behaviour, dementia awareness, and epilepsy.
• Staff told us the training provided helped them to perform their role. One staff member said, "We had manual handling training. We also did first aid. Training does help a lot and good to learn more." Another staff member commented, "We have had a few training courses like medication. We have done quite a few."
• Staff felt supported and received supervision and annual appraisals. One staff member said, "We talk about anything I want to change or any changes in the [people who used the service]. If I am happy with my rota. If I have any problems I want to discuss."

Supporting people to eat and drink enough to maintain a balanced diet:
• Most people were supported by their relatives with their meal preparation.
• Care records showed how people's dietary needs were assessed, such as their food and drink preferences and how they should be assisted with their meals. For example, one care plan stated, "I am not keen on fizzy drinks but fruits juices and the occasional glass of water. When making my [specialised] tea please put my tea bag into a sauce pan with some of the herbs located in the kitchen cupboard. I will show you. All my food and drink should be served on the small table next to my chair in the lounge and I want my carer worker to

support me to eat by feeding me with a spoon."
• Staff recorded what people ate and drank in the daily care logs to enable them to monitor their food and fluid intake.

Staff working with other agencies to provide consistent, effective, timely care:
• The service worked with other agencies and professionals to ensure people received effective care.
• Where people required support from other professionals this was supported and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as GPs, and health and social services. Records of communication and correspondence confirmed this.

Supporting people to live healthier lives, access healthcare services and support:
• Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. One staff member told us, "I would ask [person] how they feel. If it was really bad I would call the ambulance. They have all the doctor's details in the care plan folder. Also, next of kin in an emergency."
• A relative told us, "If I need, [staff member] will come to the GP and hospital with me. Without them I could not have done it. Last year [relative] was really ill and had to go hospital and the [staff member] supported me." Another relative said, "They let me know if [relative] not well. They pass on information to district nurses."
• Records showed the service worked with other agencies to promote people's health such as district nurses, GPs, palliative care team and pharmacists.

Ensuring consent to care and treatment in line with law and guidance:
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.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staff ensured that people were involved in decisions about their care, and understood the procedures to make sure decisions were taken in people's best interests. One staff member told us, "We have to ask even to open the fridge. I have to ask everything. I will ask how they want to be washed." Another staff member said, "I will always ask before I help [people]. I will ask to wash their hair or help with all things. Ask what they [want] for breakfast. It's about choice. You have to always let them know what I am doing."
• A relative told us, "[Staff] explain what they are doing." Another relative said, "[Staff] do give [relative] choice. My [relative] is very stubborn. You have to talk and talk to get things right. The [staff member] had to spend half an hour to encourage her to get ready and bathed."
• Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions.
• We spoke to staff and found they had a good understanding of the principles of the MCA.
• Records showed that people had agreed to their care plan by signing a consent to care agreement form. Relatives were involved in making decisions where people lacked capacity. Records confirmed the service had information on applications for Lasting Power of Attorney documentation when people were unable to make their own decisions.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
• People and their relatives told us that staff were caring. One person said, "[Staff] look after me very well." A relative told us, "[Staff] are very gentle and kind. They will slowly help [relative]. You have to work with her like that or she gets angry." Another relative said, "[Staff] treat her as a person [rather] than a patient. They talk to her and include her in their conversations. Sometimes stay longer to have a chat with her."
• Staff showed a good awareness of people's individual needs and preferences. Staff talked about people in a caring and respectful way. One staff member said, "With the [person] I look after I have a good relationship with them. I just clicked with my [person]. When I meet [people] I take them into my heart. I look after [them] like they are my own. We just bond." Another staff member told us, "With me, I am very patient and very talkative with [people who used the service]. Sometimes the [relative] says 'what would I do without you'. [Person] says 'I love you' and 'you are my favourite'."
• The service recorded compliments from people and their relatives. This showed they found staff to be caring and kind. Comments included, "I am so grateful that they treated my [relative] with dignity and respect at all times. [Staff] never rushed with their duties and were always with my [relative] for the duration of their allocated time. My [relative] was looked after gently and caringly. Even when my [relative] passed away, the support to the family didn't just stop" and "Without exception [staff] are just about the most caring and dedicated team I have come across in a long time. Every time the district nurses visit they are complimentary about the way in which [relative] is cared for."
• People's care plans recorded their needs in relation to their gender, sexuality, gender preference of care, culture and religion. This enabled the service to meet people's needs in relation to their protected characteristics.
• It is unlawful to treat people with discrimination because of who they are. The Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected under the Act.
• The service promoted and encouraged lesbian, gay, bisexual and transgender (LGBT) people to use their service. The registered manager told us, "We would support them how they would want to be supported. We would liaise with gay and lesbian groups to get advice and support. We would look at recruiting people of a similar sexuality. We would go to [specific LGBT organisation]." A staff member said, "[LGBT people] are no different. I would have to treat them how they would want to be treated." Another staff member commented, "They are a person. They are human beings."
• Training records showed staff had completed diversity and equality training.

Supporting people to express their views and be involved in making decisions about their care:
• People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support they received.
• Records showed people who used the service and relatives were involved in care planning and reviews.

One relative said, "I was involved with [care plan review]. [Provider] reviews every two or three months to check everything ok." Another relative told us, "Have got a review due soon. I think it is every quarter. [Provider] would come down and we go through the care plan. They give me a day or so before I sign it."

Respecting and promoting people's privacy, dignity and independence:
• People and their relatives told us their privacy and dignity were respected. One relative said, "[Staff] have definitely built a bond with [relative]. I hear the conversations and I can tell they care and treat her with respect."
• Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "I will always ask [people] before I do anything because it is their home and I have to respect them." Another staff member said, "If someone wants to go to the toilet. I will leave them and close the door."
• Staff promoted and encouraged people's independence. A staff member told us, "With [person] I cook for her and do things but I will ask her if she wants to cook. She will tell me what she can do. She can't stand for long and tells me she will sit down. She might come back and ask to help and continue." Another staff member said, "I see what people can do. I don't rush them. I wait and see what they can do themselves."
• One person told us, "[Staff] help me with a shower. I stand there and turn my back and let them do it. They let me do things myself."
• Promoting independence was reflected in people's care plans and this enabled staff to support people to maintain their independence. One care plan stated, "Can wash most parts of the body. [Needs] help with feet and back."

Good

Is the service responsive?

Our findings

Responsive – this means that the service met people's needs

At our last inspection on 5 December 2017, this key question was rated "requires improvement". We found the level of detail in care plans was not consistent. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question responsive to at least "good". At this inspection, we found the provider had taken steps to improve the detail in people's care plans. Therefore, the rating has changed to "good".

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People's care and support plans gave staff information on their background history, likes, dislikes, healthcare needs, routines, how they would like to be supported and preferred care visit times. For example, one care plan stated, "[Person] treasures her time alone in her room. She returns home from her daily outing at 3.00pm. She spends time in her room relaxing, listening to music or playing video games." Another care plan stated, "Always speak with [person] about her requirements before starting tasks. Listen to her carefully as she speaks very quiet."
• People and their relatives told us the service was responsive and met people's personalised needs. A relative said, "Pressure sore has healed. That's down to dietary intake and the [staff] cleaning and looking after [relative]. If wasn't for them the pressure sore would have taken longer to heal."
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• The care documentation clearly showed that the service identified and recorded communication impairments.
• People's cultural and religious needs were respected when planning and delivering care. Records showed people had discussions of their spiritual faith during the care planning process. Staff were aware some people required culturally specific food and this was reflected in care records.

Improving care quality in response to complaints or concerns:
• People's feedback, concerns, complaints and compliments were recorded.
• Staff knew how to provide feedback to the management team about their experiences which included supervision sessions and team meetings. A staff member said, "I tell [people] if they don't like [the] way we are working they can complain to the agency."
• People and their relatives were aware of how to make a complaint. A relative said, "I would go to [registered manager] and tell him. He would speak to the carers and find the right solution." Another relative told us, "I would speak to [registered manager]."
• Records showed the service had received one complaint since the last inspection. We found the complaint was investigated appropriately, and the service had provided a resolution to the complaint.

End of life care and support:

• The provider had an end of life care policy that detailed how to support people receiving palliative and end of life care.

• The registered manager told us one person was being supported with end of life and palliative care. The person was also supported by a palliative care team. The palliative care team had created an end of life care plan which the provider used for guidance and information. Records showed the provider and palliative care team worked together to support the person.

• Records showed staff received end of life and palliative care training.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At our last inspection on 5 December 2017, this key question was rated "requires improvement". We found quality assurance systems were not robust in identifying inconsistencies in care plans and risks assessments. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question well-led to at least "good". At this inspection, we found the provider had taken steps to improve the quality assurance processes. Therefore, the rating has changed to "good".

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The service had a number of effective quality monitoring systems in place. These were used to continually review and improve the service.
• Records showed the provider conducted quarterly care plan audits and monthly medicines checks.
• The provider also conducted regular quality reviews of the care being provided. The reviews included talking to people who used the service, feedback on staff and care being provided. One comment included, "Reliable and caring. Very lively and good relationship with carers and office."
• Spot checks were regularly conducted. The spot checks looked at attendance, care plan tasks, medicine records, observations, and feedback from people who used the service and relatives. One staff member told us, "The care coordinator checks what I do and to see if I understand what I do. Think they check every six months." A relative said, "They do have spot checks."
• Staff spoke positively about the registered manager. One staff member said, "[Registered manager] is really good. [Registered manager] is someone who cares a lot. He treats us as we are part of one family. He will always ask how we are dealing with the [people who used the service]. He will call you at least once a week to see how you are doing." Another staff member told us, "[Registered manager] is very good at communication. He knows what he is doing. I don't have a problem with him. I can call him anytime."
• The registered manager had a clear understanding of his role and the organisation.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• People and their relatives told us they felt the service was well run and responsive to their concerns and needs. A relative said, "[Registered manager] is very good. I am very happy with Aspire. I have known [registered manager] for many years. [The service] is very good. I get the service I require. It does help me in every way." Another relative told us, "[Registered manager] is good. He is very fair. They are a good company and very caring."
• Effective communication systems were in place to ensure that staff were kept up to date with any changes

to people's care and support systems. For example, staff meetings were held on a monthly basis. One staff member said, "We have every month. We talk about everything. How we should look after the [people who used the service. If any issues to report." Another staff member told us, "Staff meetings are every month. We talk about different things. About timesheets, training and people who use the service."
• The service had a policy and an understanding of their responsibility of duty of candour. Duty of candour is intended to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
• The registered manager said, "Things should not be swept under the carpet. It's about transparency. If we have wronged someone we should be open and apologise about it. We have to learn lessons and moved forward."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The provider engaged with people, relatives and staff on an ongoing basis to keep them updated and informed of any changes.
• The quality of the service was also monitored through the use of a survey to get the views of people who used the service and their relatives. The last survey was sent out in November 2018. Overall the results were positive. One comment included, "[Staff] understand my [relative's] needs and provide [the] best possible service. They understand her disability and behaviour. The care is excellent and we are very satisfied."
• The service also monitored the quality of the service with a staff survey. The last survey sent to staff was in December 2018. Overall the feedback was positive.
• The service ensured that care staff were highly motivated and offered care and support. The registered manager told us the service had a monthly award for the care staff. They said, "We look at an outstanding carer who has done something amazing. We surprise them at the staff meeting. Usually it is [people] who will tell us. It is a £50 voucher and a thank you card."

Continuous learning and improving care:
• Throughout our inspection we saw evidence the registered manager was committed to drive continuous improvement.
• The registered manager had just completed a qualification in health and social care management.
• There was a quality assurance programme in place.
• The registered manager told us they attended local authority and clinical commissioning group meetings to share and receive information. They said, "I also use Skills for Care. It is a good resource for us. We get a monthly subscription and information that comes through. It's about learning good practice." Skills for Care is an independent registered charity working with adult social care employers to set the standards and qualifications to provide staff in the health and social care field with the skills and knowledge needed to deliver high quality care.

Working in partnership with others:
• The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us the service had worked with the local authority, clinical commissioning group (CCG), and local health services. The registered manager said, "Worked with the psychology team. It was great. They help support challenging behaviour. It really helped. We work with GPs, pharmacists, CCG, sometimes hospices [for people] end of life."