Access Community Services Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Access Community Services Limited is based in Southport, Merseyside and provides personal care and support to people who may live in their own homes. Support packages are also provided to people with learning disabilities or mental health conditions, to enable them to live in the community and lead full and active lives. The service covers people requiring support in Sefton, Liverpool and Lancashire.

This was an announced inspection which took place over three days between 11 and 27 May 2016. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not always work in accordance with the Mental Capacity Act 2005. Care planning did not contain enough detail regarding people's decisions around key issues. There was a lack current evidence of people's mental capacity being assessed.

We told the provider to take action.

Medicines were administered safely. Medication administration records [MARs] were completed in line with the services policies and good practice guidance.
We were able to speak with people at the two supported living locations we visited. They looked relaxed and had an obvious positive rapport with the staff members providing support. Those able to express an opinion said they felt safe with the support they received.

We saw that people requiring support when out in the community to ensure they were safe, had fully developed plans in place. Staff were arranged to support this depending on each person's needs. There were sufficient staff available to support people.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files and found that appropriate applications, references and security [police] checks had been carried out. These checks had been made so that staff employed were 'fit' to work with people who might be vulnerable.

The staff we spoke with clearly described how they recognised abuse and the action they took to ensure actual or potential harm was reported. All of the staff we spoke with were clear about the need to report through any concerns they had. There had been two safeguarding referrals and investigations since our last

inspection of the service. Agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This rigour helped ensure people were kept safe and their rights upheld.

Arrangements were in place for checking the care environments to ensure they were safe.

We observed staff provide support and the interactions we saw showed how staff communicated and supported people as individuals. Feedback from people, their relative's and care professionals told us that staff seemed well trained and competent. Communication between relatives, people being supported, staff and senior management was effective.

Staff were supported by on-going training, supervision, appraisal and staff meetings. Formal qualifications in care were offered to staff as part of their development.
Local health care professionals, such as the person's GP, and Community Mental Health Team were involved with people. The feedback we received from people using the services, professionals and relatives evidenced good liaison and appropriate working to ensure people received good health care support.

We discussed with staff and the people living in supported living how meals were organised. We saw that these were organised individually and people were encouraged to choose and plan their own meals.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

We saw that staff respected people's right to privacy and to be treated with dignity.

All family members and people spoken with felt confident to express concerns and complaints. Issues were dealt with and the service was responsive to any concerns raised.

All of the managers we spoke with were able to talk positively about the importance of a 'person centred approach' to care. Meaning care was centred on the needs of each individual rather than the person having to fit into a set model within the service. People using the service and relatives told us they felt the culture of the organisation was fair and open.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes both internally and external to the service. There was a clear management hierarchy and we saw that new ideas and service improvements were effectively developed and communicated.

Internally there were other key audits carried out to monitor standards.

You can see what action we told the provider to take at the back of the full version of this report
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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered safely. Medication administration records [MARs] were completed in line with the services policies and good practice guidance.

There was a good level of understanding regarding how safe care was managed. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure they are safe.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff employed to help ensure people were cared for flexibly and in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not always work in accordance with the Mental Capacity Act 2005. Care planning did not contain enough detail regarding people's decisions around key issues. There was a lack current evidence of people's mental capacity being assessed.

Systems were in place to provide staff support. This included on-going training, staff supervision, appraisals and staff meetings.

People's care documents showed details about people's medical conditions and also appointments with health care professionals such as, GPs and district nurse team to help support people in their own home, supported living or shared lives.

Staff said they were supported through induction, supervision, appraisal and the service's training programme.

Is the service caring?

Good

The service was caring.

The feedback we received evidenced a caring service. People being supported and their relatives and care professionals commented positively on how the staff approached care.

We observed positive interactions between people being supported. Carers treated people with respect and dignity. They had a good understanding of people's needs and preferences.

People we spoke with and relatives told us the manager's and staff communicated with them effectively about changes to care and involved them in any plans and decisions

Is the service responsive?

Good

The service was responsive.

People's care was planned so it was personalised and reflected their current and on-going care needs.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed

Is the service well-led?

Good

The service was well led.

The registered manager provided an effective lead in the service and was supported by two deputies and a clear management structure.

We found an open and person-centred culture. This was evidenced throughout for all of the interviews conducted through to observations of care and records reviewed.

There were systems in place to gather feedback from people so that the service was developed with respect to their needs.

Access Community Services Limited

Detailed findings

Background to this inspection

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

This was an announced inspection which took place over three days between 11 and 27 May 2016. The inspection was carried out by an adult social care inspector and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert contacted people and their relatives by phone to seek their views.

Prior to the inspection we accessed and reviewed the Provider Information Return (PIR) as we had requested this of the provider before the inspection. The 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. We also reviewed other information we held about the service.

Also, prior to the inspection we sent out a number of survey forms to canvass people's opinions about the service and we received 11 back.

On the second day of the inspection we visited two of the supported living [tenanted] locations where people lived who were supported by the service. During the visits we were able to see and interact with four of the people who lived there. On 27 May we visited the central offices for Access Community Services Limited. We also contacted and received feedback form another eight people who used the service and one relative.

We spoke with nine staff including care/support staff, three senior managers for the services and the registered manager. We looked at the care records for three of the people being supported in supported

tenancies, including medication records, and one care record for a person being supported in their own home; two staff recruitment files and other records relevant to the quality monitoring of the service such as safety audits and quality audits. We also received feedback from three family members of people being supported as well as two professionals who have had input into the service.

Good

Is the service safe?

Our findings

We reviewed medication management in one of the supported living houses we visited. We spoke with care staff and the house manager and reviewed medication administration records [MAR] for the people living there. Medication was stored in a separate secured cabinet for each person. We were told that all medicines were administered by designated staff members who had received the required training. Following each individual administration the records were completed by the staff. This helped reduce the risk of errors occurring. Medicine administration records we saw were completed for that day to show that people had received their medication.

Some people were on medicines to be given when needed [PRN]. Most of these medicines had a support plan in place [PRN care plan] which told us when the medicines should be given and in what circumstances. This helped ensure consistent administration of these medicines. We saw that not all PRN medicines had a support plan. For example external medicines [creams] and people taking inhalers to help with respiratory conditions. The registered manager said this would be addressed.

We saw that medicines were routinely audited in-house and these had picked up some issues that had been addressed such as minor recording issues on MAR charts and labelling of newly opened medicines. In-house audits were supported by 'spot check' audits carried out by another house manager.

The agencies medication policy was seen and covered all areas of medication administration. We saw the policy referenced previous regulations which have now been superseded. The registered manager said the policy would be updated to reflect this.

We were told the competency of staff to administer medicines was formally assessed to help make sure they had the necessary skills and understanding to safely administer medicines. We spoke with staff who told us that competency checks were made by the house manager following initial training. This was also confirmed by the registered manager and when we looked at staff records we saw an example of these assessments.

Those people able to express an opinion in both houses said they felt safe with the support they received. All of the people we saw were relaxed in the company of staff and raised no concerns. One person said, "The staff are very good at helping me out. I like living here.''

People requiring staff support when out in the community, to ensure they were safe and appropriately supported, had fully developed plans in place. We saw identified risks had been assessed. For example one persons 'street safety' and risks around neglect of personal hygiene. Staff support was assessed and provided in consultation with each person and developed to take in to account their individual care needs. We saw this was detailed in people's support plans we viewed. People were out with staff support on the days of our inspection visit.

All of the people in the supported living accommodation [that could express a view] felt that support was

being provided in a safe, secure environment. When we contacted people being supported as part of the agency's outreach service [being supported by care packages at home] we were told similarly; people commented, "Yes I am safe here", " Yes I feel safe" and "I have no problems at all.''

We asked about staffing. Staff input was agreed depending on assessment and funding by social services. Most of the people we spoke with in the supported living accommodation needed 'one to one' support whilst out in the community for developing social skills outside of the supported living environment. We saw from the duty rotas that the houses were covered adequately. We saw staff escorting people out for the day as part of their routine. Extra cover was generally by staff who knew the people being supported.

We spoke with people receiving care from the outreach service who told us that staff always turned up on time and were very reliable. This was seen as the most reassuring element in terms of feeling secure with the care provided. People said there were enough staff employed by the service. One person said, 'I have the same staff, they are the same ones" and a relative commented, "(Person) tends to have the one carer.''

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files of staff more recently recruited and found that appropriate applications, references and security [police] checks had been carried out. These checks had been made so that staff employed were 'fit' to work with people who might be vulnerable. We spoke with staff who told us they felt the agency had been thorough in their recruitment.

All of the staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. During the inspection we were advised by the manager of the community service that a concern had been received regarding alleged abuse. This was reported through appropriately and the manager liaised with the Local Authority safeguarding team to progress any investigation.

There have been two safeguarding incidents since our last inspection. The first was in May 2015 which the agency reported through to safeguarding. The issues were around provision of regular staff to support people. This was resolved and the agency worked well with the Local Authority at the time.

The second was more recent and is still on-going. This involved issues around tenancy agreements of a person living in a supported living accommodation. The agency were liaising and working with the Local Authority and social work teams regarding this.

Agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This rigour helped ensure people were kept safe and their rights upheld. We saw that local contact numbers for safeguarding were available.

Arrangements were in place for checking the care environments to ensure they were safe. Both supported living environments were owned by a housing association and we saw there were protocols in place so that staff monitored the environment and reported through any issues. For example at the supported living services we visited, the house manager carried out documented checks of the environment.

Amongst the records seen we observed each person had a personal evacuation plan [PEEP] in case of an emergency such as a fire incident.

We looked at some records of people receiving support from the community service and saw that there were

assessments of the care environment when people where initially assessed by the service. These included a risk assessment looking at health and safety issues such as moving and handling and equipment such as wheelchair assessment and a hoist.

Accidents and incidents were recorded and monitored by the service. We saw how these were collated and analysed by the registered manager for the service.

We saw that both of the supported tenancies we visited were maintained with attention to a clean and hygienic environment. The Provider Information Return, submitted prior to the inspection, told us about an infectious outbreak in one of the houses. The evidence from this showed that the agency liaised well with local infection control officers and the incident was managed very successfully.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the home 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.

Prior to the inspection we were made aware of a safeguarding investigation conducted by the Local Authority involving two of the people living in tenanted accommodation. This involved agreement around tenancy's and the provider, in this instance, did not follow the MCA framework in getting legal consent. For example in one case the person was allowed to sign the tenancy with their legal representative not being aware. Both of the individuals were said to lack to the capacity to make these decisions.

When we spoke with the registered manager regarding this we were told that the provider had got the tenancies signed with the best interests of the people involved. We were shown the services information sheets given to people to explain tenancies these included an 'easy read' version. This supported people to understand and help them make decisions in this area. We looked at the tenancy agreements for three of the people living in the supported tenancy houses we visited. The tenancies were not clear. One contained no information at all and was not signed or dated. The other two we saw were dated 2008 and signed by the people concerned. In one instance however staff told us the person's capacity to understand the tenancy was at least questionable. Tenancies had not been updated since. There was no evidence of an assessment of the person's mental capacity undertaken with respect to this decision.

The registered manager explained that any new tenancies were carried out with reference to the MCA. The tenancies we saw started prior to the full implementation of the MCA. The service had been advised by social workers that tenancies would be reviewed as part of the on-going social work reviews. We spoke with a social worker at the local authority who confirmed this arrangement on-going.

When we visited people living in supported living we found some examples of good practice which evidenced that the service where aware of the workings of the MCA, but we found there was need for further improvements.

Staff told us that time needed to be taken to help ensure people were supported to make decisions. For example, we saw a support plan which told us one person was at risk of going out of their home without staff support. This had placed certain restrictions on the person's movement as they could only go out at certain times when staff were available. The staff we spoke with were aware of the issues surrounding this and understood the concept of making decisions of the person based on their best interest in ensuring they were kept safe. In this example, and others, however, there was no indication that a formal assessment of the person's mental capacity had been made with respect to this decision and recorded in the care file.

The house manager, in both houses we visited, showed us an example of a mental capacity assessment tool they had discussed at a team leaders meeting. They said they would introduce this with respect to existing and future best interest decisions.

We looked to see how people's personal allowance and finances were managed. Staff were able to discuss arrangements although some of these were not clear. For example staff were not sure of the legal status of relatives and whether any had Lasting Power of Attorney [LPA] to manage and make decisions regarding peoples finances and/or health. Following discussion with registered manager it was clear that at least one person's relative had such legal responsibility. When we looked at care records there was no reference to this. There was no clear care plan for the person around finances and how these would be managed day to day and with respect to key decisions.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw positive reference to decisions being made in people's best interests involving family, support workers and advocacy if necessary. A good example we saw of this was a best interest decision regarding a person who had to have treatment in hospital for a medical condition. This had involved the person's relatives and health care professionals. We saw that in this example the person mental capacity had been assessed with respect to this decision. These assessments helped identify people who may need referring legally to the Court of Protection [COP]. The COP provides a legal framework for making decisions for people living in the community who lack capacity. A staff member told us, "We have all completed training around mental capacity."

Access Community Services Limited provided support for people in two designated services; supported living and outreach. These supported people who have a learning disability or need support with other mental health care needs which can affect their quality of life. When we spoke with staff the main aim of the support was to encourage people to be as independent as possible and enjoy as full a daily life as possible based on people's individual chosen lifestyles.

We observed staff provide support, particularly in the supported living houses we visited. The interactions we saw showed how staff communicated and supported people as individuals. Staff were able to explain in detail each person's care needs and how they communicated these needs. We saw care records included reference to peoples preferred method of communication.

One person spoke with us and told us about a project they were involved in and how staff supported them to carry this out. We observed the person had good rapport with staff who supported them on a 'one to one' basis. This person was encouraged to be independent, for example using public transport with support. We received positive feedback for people being supported by the outreach service. They said the quality of the service was good and commented; ''They are very good", "I couldn't be happier" and "They take me out and are fine.'' A relative said "We are very happy with them. We've had them for a long time.''

Relatives we spoke with told us that staff seemed well trained and competent. We were told support staff appeared to have a range of life skills and were seen to be doing a very good job. A relative commented; ''Yes, all the staff are well trained.'' We saw comments from the services feedback survey; one said, ''Each staff have their own skills which I think is good.''

Communication between relatives, people being supported, staff and senior management was seen as effective. All of the relatives spoken with felt they were kept up to date with any changes or developments.

They felt staff had the skills and approach needed to ensure people were receiving the right care.

We looked at the training and support in place for staff. The PIR told us; 'We have our own training company (Access Community Training) and therefore are able to tailor our training to ensure that specific identified needs and goals are met'. We had positive feedback from staff who said the training provided and support offered by the service was good. The training manager gave us an overview of the training for staff. All of the staff we spoke with had a standard qualification such as NVQ [National Vocational Qualification] or Diploma and the training manager told us all staff had such a qualification – most at level 3. This was confirmed by records we saw. New staff received an induction training package. More recently this has been based around the new Care Certificate. Additional training was on a regular scheduled basis which staff can access. We saw the training schedule for the year with courses booked every month. The service benefited from a training room and close links with Southport and Skelmersdale College.

In addition some staff had undertaken training with respect to the care needs of the people being supported. For example we spoke with a care staff from supported living who had attended training around epilepsy as this was background knowledge needed to support people in that particular accommodation.

Staff told us there were support systems in place such as supervision sessions and staff meetings. We were told; ''We are supported really well. Managers are very accessible if we need any support.'' House managers said they have regular monthly meetings with senior managers to discuss any issues and get updates and feedback. The registered manager told us about the one to one sessions [supervision] that house managers receive and we saw copies of notes of these. Currently staff do not have a yearly appraisal. The registered manager said they would introduce appraisals this year.

We saw, from the care records that local health care professionals, such as the person's GP, and Community Mental Health Team were regularly involved with people. One person we spoke with said staff supported them to attend the doctors or any other health appointments. We saw some feedback in a survey form from a health care professional which said, '[The service] have the best interests of the service users at the forefront'. Another commented, ''Staff are always aware of my visits.'' A professional we surveyed agreed, 'Care agency staff are competent to provide the care and support required by people who use this service'.

We saw from the care files we reviewed people had access to health care professionals when they needed them; for example district nurses, occupational therapists or a GP. Care files we reviewed in both of these services evidenced this.

We discussed with staff and the people living in supported living how meals were organised. We saw that these were organised individually and people were encouraged to choose and plan their own meals. Each of the care plans we saw contained a health action plan and this also contained any plans to support people who needed dietary input. We saw that people in supported living were supported to do their own shopping for food.

Good

Is the service caring?

Our findings

We received positive feedback from all areas of the service regarding the caring nature of the staff. Comments we received included: ''They are lovely", "Staff are kind", "They are nice and funny", "Carers are good", and "Yes they are very good.'' We saw a comment from a care professional in a recent survey by the service which said, ''[The staff] give very person centred care.'' A relative commented, ''We are always asked to go to reviews and we are given copies of support plans.''

We observed the interactions between staff and people living in supported living accommodation. We saw there was an obvious rapport and understanding. People varied in their level of care need and communication. This meant people needed support interventions aimed at planning their day and future activity on an individual basis.

Communication was seen as a priority to carrying out care. Care files referenced individual ways that people communicated and made their needs known. We also saw examples were people had been included in the care planning, so they could see and play an active role in their progress. This included a review of care for a person having community support.

Most people in supported living had designated periods of 'one to one' staff who supported them on a daily basis. We saw staff respond in a timely and flexible way depending on how each person communicated. We saw there was positive and on-going interaction between people and staff. We heard staff taking time to explain things clearly to people in a way they understood. When we spoke with staff they were able to tell us why people needed different approaches at certain times and how this had been agreed and was consistent.

The staff we spoke with had a good knowledge of people's needs and were able to explain in detail each person's preferences and daily routine, likes and dislikes. These were also recorded in care files we reviewed. This theme was supported by the observations, interviews and records we saw on the inspection.

We saw that staff respected people's privacy and were careful to maintain their dignity. On one occasion a person was behaving in an excitable manner when talking to us and the care staff responded in a timely way to support and reassure the person concerned to maintain their dignity.

We asked about advocacy service available for people. We saw that local advocacy service was advertised in the drop in facility operated at the services offices. There was full information available including contact numbers.

We saw some people who were attending the drop in facility and they looked relaxed and were socialising with each other. There were two large display boards which evidenced 'Great things in 2015' and 'Achievements so far in 2016'. These included many of the activities that people being supported had been engaged in. This further evidenced people's level of inclusion with the service and their on-going care.

Good

Is the service responsive?

Our findings

When we spoke with people on the inspection and made observations we found the care to be organised to meet people's needs as individuals. For example we reviewed some of the daily activities and routines people were engaged in. These were varied and had been chosen by the people concerned.

We were able to speak with people at the two supported living locations we visited. People were settled and some were keen to tell us about their day and how they were supported. All of the people we saw and spoke with appeared comfortable with the support they were receiving from the care staff and had an obvious warm rapport.

One person was keen to show us there personal care file. This contained photos of the person engaged in various activities. The person spoke positively and enthusiastically about these. Staff in attendance were careful to offer encouragement and prompting to assist with communication. The person also told us about their plans for the day and how they spent the rest of their week. They had an obvious positive relationship with the staff member providing support.

Care records contained individual life histories and events as well as recording the way any personal care should be delivered. We found that care plans and records were individualised to people's preferences and reflected their identified needs. There was evidence that plans had been discussed with people and also their relatives if needed. We could see from the care records that staff reviewed each person's care.

The care records we looked at for people on community support clearly identified the key areas of care and how these would be supported. It was also clear how elements of this were supported by input from health professionals. An 'action log' gave a running update regarding plans made. We saw references to discussions around holiday planning and a wheelchair assessment that had taken place. One care record /plan we saw was dated from 2002. Although there was evidence of updates as entries had been added, these were very brief. We discussed from a quality perspective the need to ensure care plans were rewritten and dated more recently.

We saw the personal care element of the care plans were well defined so it was clear for staff how this was to be carried out. For example we saw a very detailed assessment and care plan covering one person's mobility.

We received feedback which evidenced a personalised approached to care. One relative commented on a survey form: ''There is always someone available to talk to.'' A person using the service told us, ''They listen to me.'' Another commented, I do shopping with [carer] and if I get forgetful they are there to help.''

People we spoke with told us they had meetings [reviews] and were involved in planning their care. We saw these meetings recorded in the care files we reviewed for people in supported living. A social worker had commented in one review, ''The service is successful at meeting needs. [Person] is very stable.''

The PIR form gave us an example of a person who had benefited from this individualised approach. A relative had fed back to the service, '' The team are extremely caring, loving and understanding. When planning trips, it is clear that they know [person's] needs so well. All requirements have been researched, even to the extent of bringing [person's] favourite marmalade and magazines.''

A further example was seen when we visited the service's offices. During the afternoon it had been arrange for the care staff involved with a new, soon to be, tenant were meeting in a 'meet and greet' meeting so that the person and relatives would be fully aware of who the care team were and could ask any questions.

We asked people and their relatives if they were listened to if they had any issues or concerns. People we spoke with and relatives said they knew how to complain but had no wish to do so. The complaints procedure was accessible and included an easy read version.

We reviewed one complaint / issue that had arisen which was around the 'professional' boundaries for staff and confidentiality. We saw this had been followed through with staff concerned as well as providing an opportunity for learning in a wider sense with staff.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager was supported by senior care managers [deputies] for each of the services provided by Access Community Services Limited.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes both internally and external to the service.

The PIR gave some information regarding quality assurance processes. This told us the service was signed up to the 'Driving up Quality' initiative, Investors In People accreditation and use of business consultancy for health and safety and employment law, good networking and partnership work with local authorities and attendance at provider meetings in Sefton, Lancashire and Liverpool.

We saw the self-assessment carried out by the service under the Driving up Quality initiative. This is a government initiative following the review of care after the Winterbourne enquiry. The assessment included the use of feedback from people using the service, relatives and various stakeholders such as community professionals. From this the registered manager had been able to set various action plans to further develop the service.

The service had received feedback for the Driving up Quality Alliance in August 2015 which said: 'Your self-assessment report had a clear introduction to set the context, was clearly laid out and easy to read and understand, and included the views of all stakeholders. I liked the clear action plan at the end of each section'.

The registered manager and deputy's had a clear understanding of the quality process. For example we discussed a complaint and how this had been managed. There was a clear pathway from attending feedback from a professionals meeting - to an internal management meeting - to a team leaders meeting – discussion at staff meetings and feedback to managers through the monthly reports from team leaders. This showed clear communication and learning from one incident.

Another example of a service innovation had been the development of a Facebook page for the service – this following feedback from people using the service so they could be kept up to date of any news.

The registered manager was keen to develop further feedback mechanisms and was liaising with an external organisation aimed at facilitating feedback forums for people with mental health support needs. The aim was to develop more peer advocacy in the running of the service. For example in the staff recruitment processes.

The service had just completed a series of survey questioners and we reviewed some comments from these which were all positive. The results had not yet been analysed but we were shown the results from a previous survey and some of the developments that came from this.

This approach was recognised by staff we spoke with. All commented on the openness of the service and a willingness to make things better. This open culture was further evidenced by some of the comments we revived form people who told us the service was well managed and told me "Yes the manager is good. I have no complaints", "The office is always helpful", and ''The senior is good. No problems." Relatives said "We have not had need to contact the manager [with any concerns] at all".

Internally there were other key audits carried out to monitor standards in supported living houses [for example]. This included house manager's audits covering health and safety and checking people's personal allowances. These audits were complemented by senior management audits carried out annually or bi-annually. We reviewed the yearly audit of people's finances and saw this was very comprehensive and detailed.

The service had sent us notification of incidents and events which were notifiable under current legislation. This helped us to be updated and monitored key elements of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always work in accordance with the Mental Capacity Act 2005. Care planning did not contain enough detail regarding people's decisions around key issues. There was a lack current evidence of people's mental capacity being assessed.