

Look Ahead Care and Support Limited

Stratford Road

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

Stratford Road is a small care home for people with learning disabilities who may have mental health difficulties. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This inspection took place on 25 September and 3 October 2018. The inspection was announced. This was the first inspection since the service first registered in October 2017.

The service did not have a registered manager. There was a manager in post who had applied to become registered. 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.

Staff were knowledgeable about reporting safeguarding concerns and whistleblowing. People had risk assessments carried out to mitigate the risks of harm they may face at home and in the community. Building safety checks were carried out in line with building safety requirements. The provider carried out appropriate checks on new staff before new staff began to work in the service. There were enough staff on duty to keep people safe and to meet their needs. There were systems in place to record the administration of medicines and store medicines safely. However, there were no guidelines in place for a medicine for one person which was to be used only as needed. People were protected from the risks associated with the spread of infection. Accidents and incidents were recorded and were used to learn lessons and improve the service.

People's needs were assessed before they began to use the service to make sure the right care could be provided. Staff were supported with training opportunities, supervisions and appraisals to enable them to carry out their role effectively. Communication systems were in place to keep staff and stakeholders updated on people's wellbeing. People were supported to eat nutritional and cultural food and to maintain their health. Staff understood the requirements of the Mental Capacity Act (2005) and the need to obtain consent before delivering care.

Staff explained how they developed caring relationships with people using the service. The provider had a 'keyworking' system in place where a named staff member had overall responsibility for ensuring all of a person's needs were met. Relatives were consulted and involved in decisions about care. Staff were knowledgeable about equality and diversity. People's privacy and dignity were promoted, and they were supported to maintain their independence.

Care plans were personalised and contained people's preferences. Staff understood how to deliver personalised care. People were supported to achieve their personal goals and were able to participate in a

range of activities. Staff supported people with their communication needs. The provider had a complaints procedure and an end of life care policy.

Relatives, stakeholders and staff spoke positively about the management of the service. The provider had a system to obtain feedback from people using the service and stakeholders. Staff had regular meetings to be updated on the wellbeing of people using the service, developments of the service and to make suggestions for improvement. The provider had quality assurance systems in place to identify areas of improvement. The service worked in partnership with other agencies to share examples of good practice and to improve the service provided.

We have made one recommendation about medicines management.

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. Staff were knowledgeable about safeguarding and whistleblowing procedures.

People had risk assessments in place to mitigate the risks of harm they may face. Building safety checks were carried out.

The provider had a system in place to carry out appropriate pre-employment recruitment checks. There were enough staff on duty to keep people safe and meet their needs.

There were systems in place to store medicines appropriately and record the administration of medicines. However, there was not always guidelines for staff in place for medicines to be administered on an 'as needed' basis.

People were protected from the risks associated with the spread of infection. The provider used accidents and incidents as a learning tool to make improvements.

Is the service effective?

Good ●

The service was effective. People's care needs were assessed before they began to use the service. Staff were supported to carry out their role with supervisions, appraisals and training.

People were supported to eat a nutritional and culturally appropriate diet and to maintain their health. There were communication systems in place to update the staff team and professionals on the well-being of people using the service.

Staff demonstrated they were aware of the legal framework of decision-making and the need to obtain consent before delivering care.

Is the service caring?

Good ●

The service was caring. Staff explained how they got to know

people and their care needs. Relatives were consulted and involved in decisions about the care.

People had a named care worker who had overall responsibility for the care they received.

Staff described how they treated people fairly and equally. People's privacy, dignity and independence was promoted.

Is the service responsive?

Good ●

The service was responsive. Staff understood how to provide a personalised care service. Care plans were personalised and contained people's preferences.

People were supported to achieve their personal goals and participated in a variety of activities. Care plans included people's communication needs.

The provider had a complaints procedure and an end of life policy.

Is the service well-led?

Good ●

The service was well led. Relatives, stakeholders and staff gave positive feedback about leadership at the service.

The provider had a system to obtain feedback from people using the service and stakeholders.

Staff had regular meetings to be updated and contribute to the development of the service.

The provider had quality audit systems in place to identify areas for improvement.

The service liaised with other agencies to ensure people received good quality care.

Stratford Road

Detailed findings

Background to this inspection

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

This inspection took place on 25 September and 3 October 2018 and was announced. The provider was given 24 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in. One inspector carried out this inspection.

Due to technical problems, the provider was not able to complete 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 took this into account when we inspected the service and made the judgements in this report.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We contacted the local authority with responsibility for commissioning care from the service to seek their view about the service.

During the inspection we spoke with five staff which included the manager of the service, a registered manager from another of the provider's services, the head of safeguarding and quality and two care workers. We also spoke with a visiting health professional and a relative. We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed one person's care record including risk assessments and care plans and reviewed two staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Is the service safe?

Our findings

A relative told us they felt their family member was safe using the service. The relative said, "Yes, they have got proper barriers around."

The provider had safeguarding and whistleblowing policies which gave staff clear guidance about the actions to take if they suspected somebody was being abused. Staff had received training in safeguarding adults and whistleblowing. The management team told us there had not been any safeguarding concerns since the service started but they knew the actions they would need to take should any arise.

Staff explained to us the actions they would take if they suspected abuse. One staff member told us, "You have to be proactive and notify your manager. If the manager is reluctant to respond, then you jump higher up. [Whistleblowing] is when you have an issue developing you write to management, you write to social services if you have to or the CQC. You can call them too." Another staff member said, "I have to record it, put the date the time and report it to my line manager. Whistleblowing is reporting bad practice to my line manager if he is not the one abusing and he can escalate it. If my line manager is the one doing it, I just have to go above them and report them quick to the local authority." This meant the provider had systems in place to protect people from the risk of abuse.

People had risk assessments carried out to mitigate the risks of harm they may face. These included safety in the community, behaviours that challenge services at home and in the community, absconding, self-neglect, specific health conditions and hot water. For example, one person had a risk assessment for behaviours that challenged services. Their risk assessments and management plan included two staff working with them when they left the accommodation, the Breakaway techniques that could be used and emphasised that floor or seat wrap restraints must not be used. This person also had a positive behaviour support plan (PBS) which gave guidance to staff on how to recognise when the person was becoming agitated, anxious or aggressive or calming down. The PBS also recommended the strategies to use to prevent the behaviours occurring, the support the person needed following an incident and additional guidelines for during night hours. This meant the provider took steps to mitigate the risks of harm to people.

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, a gas safety check was carried out on 18 May 2018, the five year electrical installation check was carried out on 28 September 2018 and portable electrical appliances were tested on 27 September 2018. The staff checked the water temperatures weekly and records showed these were up to date and within the correct range. A fire risk assessment was carried out on 28 September 2018 with instructions for staff on what to do in the event of a fire and fire equipment had been serviced on 23 January 2018. The weekly fire safety checklist was completed, up to date, with no issues identified and we noted a fire drill was carried out on 9 August 2018 with no concerns about the evacuation.

The provider had a recruitment policy in place which stated the pre-employment checks that must be carried out before a person was employed to work in the service. Staff records confirmed applicants had produced proof of identification, confirmation of their legal entitlement to work in the UK and written

references. New staff had undergone criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates to check their continued suitability. This meant a safe recruitment procedure was in place.

A relative told us there enough staff on duty to meet people's needs. The relative said, "They seem to manage with what they have." Staff confirmed there were enough staff on duty and one staff member told us, "Oh yes. We have a very nice team." We checked the staff rota and saw there were two staff members on duty to work with each person during the day and one staff member awake at night. This meant there were enough staff on duty to meet people's needs.

Medicines were stored in a locked cabinet. The temperature of the medicine cabinet and medicine fridge were checked daily and were within the accepted range. Medicine administration record charts were completed and signed with no gaps to indicate people had received their medicines as prescribed. All staff were given a medicine competency handbook to complete which was marked by the manger before they could administer medicines unsupervised.

People who required 'pro re nata' (PRN) medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. Reasons for giving PRN medicines were documented on the back of the MAR charts. However, we found for one person their diabetic PRN medicine did not have a PRN protocol in place. Information for this was contained within their diabetic guidelines. We recommend the provider seek advice and guidance from a reputable source about managing medicines safely.

People were protected from the risks associated with the spread of infection. During the inspection we noted the premises were clean and free from malodour. The provider had an infection control policy in place to give guidance to staff about preventing the spread of infection. A relative told us, "I always find [person] clean and tidy." Staff told us they were provided with sufficient amounts of personal protective equipment such as gloves and aprons. One staff member said, "Oh yes. We order in bulk." There were handwashing facilities available including hand soap and paper towels.

The provider had a system of recording accidents and incidents and using these to learn lessons. For example, one person using the service had tried to open the vehicle door when they saw a member of the public drop something into the bin. On this occasion, the vehicle was stationary but the lesson learnt was that locks were put onto the vehicle doors to prevent a repeat of this incident happening when the vehicle was in motion.

Is the service effective?

Our findings

A relative told us they were happy with the service provided to their family member and said, "Everything seems to be okay."

People had an assessment of their care needs before they began to use the service. Information gathered during the assessment process included the person's personal and medical history, hopes for the future, cultural and spiritual needs, communication needs, what was important to the person, what the person liked to do and relationships. For example, one person's assessment noted the garden would need a high fence fitted to minimise the possibility of absconding. This meant people's needs were assessed and important information about the person could be captured to ensure the service could meet their needs.

Staff confirmed they received opportunities for personal development. One staff member told us, "The training is unmatched and unrivalled. I am about to do a 'train the trainer' course for PBS (positive behaviour support) so I can train staff." Another staff member who had recently completed their induction training said, "Yes I did find it useful."

New staff completed a six-month probation period which included a review at three weeks and three months and the option of extending. Induction training was spread over one month including five days operational induction which included an introduction into the organisation and training in safety topics. New staff spent one week shadowing more experienced staff and reading documentation, then would take on a lead role for two weeks before progressing to medicine competency training.

Training records showed staff received training in a range of topics including fire awareness, health and safety, learning disability and autism, body language, behaviours that challenge services, diabetes awareness, epilepsy, moving and handling. This meant people were supported by suitably qualified staff.

The provider had a supervision policy. Records showed staff received supervision in line with the policy. Staff told us they received regular supervisions and found these useful. One staff member told us, "Yes they are useful. It's a forum for development." Another staff member said, "Yes I do find them useful." Topics discussed included staff wellbeing, teamwork, training, the wellbeing of people who used the service, medicine competency, budget management and regulatory issues. Staff also received an annual appraisal where they could set goals they wished to achieve during the next twelve months, document their career aspirations and review their performance over the past year. Records showed new staff had their initial appraisal meeting to set their goals and career aspirations and staff who had transferred from other services had received their annual review of their performance. This meant staff were supported to carry out their role effectively.

People were supported with their nutritional needs. A relative told us, "They give [person's] meals at the proper time. Sometimes we talk about that, like what food [person] likes." One staff member told us, "We have diagrams on [person's] wall. While [person] might not be verbal we give ideas of what [person] can have during the week. The family have given ideas of what [person] likes. They help a lot the family." Another

staff member said, "Yes [relative] likes [person] to have Jamaican, African and English food. [Relative] always reminds me."

We saw one person had a picture menu displayed in their bedroom. The menu offered a variety of nutritional cultural foods and included healthy snacks. Staff were knowledgeable about people's dietary and cultural needs. Care plans contained nutritional guidance and meal ideas for people with health specific food requirements. The kitchen was well stocked with a variety of fresh and nutritious food. Opened food was labelled with the opening date. Records showed fridge and freezer temperatures were checked daily and were within the correct range.

The provider had a system of keeping staff and outside professionals up to date with people's changing needs. A visiting professional told us, "They are very good here at communicating." Another professional from the commissioning local authority stated, "They are proactive in communicating. Excellent both verbally and written." A staff member said, "Once I come in I check the communication book and we have verbal handover." The managers told us, "With professionals we do a monthly update. They arrange visits whenever they want it."

People were supported to maintain their health. One staff member told us, "That's imperative. We have to work with the diabetic nurses, the consultants and we have to make sure the diabetic plan is maintained. We document everything we do. Blood pressure, heart beat and blood sugar levels." This staff member showed me the blood sugar bar chart they had developed to be able to show health professionals at a glance. Another staff member said, "I take [person] on a walk, I do some of [person's] activities with [them], go swimming with [person] and the male staff. Sometimes we do some dancing. I've taken [person] on medical appointments several times before."

Records confirmed people had access to the GP, optician, dentist, podiatrist and neurologist as required. One person's care file contained a learning disability occupational therapy report. People had a hospital passport and health specific care plans.

The premises were a purpose built single storey building with a garden area outside. At the time of this inspection nobody using the service had mobility needs but the entrance to the building was accessible by a wheelchair ramp in case this was needed in the future.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of this inspection, there was one person with a legally authorised DoLS in place. Records showed assessments and decision-making processes had been followed correctly.

Staff received training in the MCA and DoLS and demonstrated they understood these. One staff member

told us, "For those who do not have capacity, the social services have to do an assessment to see if they have capacity and if not they have to appoint somebody to make decisions for them. The DoLS is to make sure person is protected. For example, [person] cannot be allowed to rove the public on [their] own so we provide the loving support and guidance to protect [person] in the community." Another staff member said, "[MCA] does not mean that person doesn't have capacity every day. They may not have capacity today but does not mean they won't have it tomorrow. You gave to get [DoLS] from the court. You have to do an assessment first. You cannot just deprive someone of their liberty."

Staff demonstrated they understood the need to obtain consent before delivering care. One staff member told us, "There is certain things you need to get that consent. Like asking, 'Are you ready for your personal care?' You show the person what is required. You do not demand. You need to show dignified respect." Another staff member said, "If I want to change [person's] clothes, even though [they] are non-verbal [they] can let you know if [they] consent. Sometimes signs for yes, shakes their head or does it with body language." This showed the provider had systems in place to work within the requirements of MCA and DoLS legislation.

Is the service caring?

Our findings

A relative and a professional from the local authority told us staff were caring. A relative said, "Yes, they are all right. I think they do a good job." The professional from the local authority stated, "The person-centred holistic quality of their care throughout transition, discharge and ongoing care was excellent." There was a calm, relaxed and happy atmosphere throughout the home. We observed people could choose where they wanted to spend time and were able to choose to spend time on their own in their bedroom if they wished.

Staff explained how they developed positive relationships with people from when they first began to use the service. One staff member told us, "First we do the assessment and getting [information] direct from the family and observation are key factors that must be applied. Spend time observing behavioural patterns. [Person] takes the lead in showing us what [they] want." Another staff member said, "First I read the care plan, then we attend training. Talking to [person's] family and by working with them." This meant care was provided to people by staff who knew what support they required.

The provider had a keyworker system. The keyworker was a named staff member who had responsibility for ensuring all the person's needs were met and the living environment was safe. This included ensuring documentation was up to date, being the person's advocate and giving them a voice. As this was a small service, people had a named keyworker but the keyworking responsibilities were shared amongst all staff. Records showed keyworking sessions were held every two months with each person and were documented in a pictorial format to enable people to understand them. The sessions included any changes made to the person's support since the previous session and important events that had occurred.

Relatives were involved in decisions about the care provided. A manager told us, "For the family we have a coffee morning quarterly which is a forum for the family to air any concerns they may have, and we give a full feedback of monthly summaries. They [relatives] can tell us if we need to be doing something and we tell them how we are going to do it." A relative confirmed this was the case. One staff member told us, "Family are very much involved. When they come here they feel welcome. They feel a sense of security." Another staff member said, "If we are doing something that is new, when [relative] calls we tell her and ask her if she is okay with it and [another relative] comes once or twice a week and we tell them. Sometimes the manager may send [relative] an email to keep them updated." This staff member explained that relatives may offer suggestions to help.

The provider had an equality and diversity policy which gave guidance to staff about providing an equitable service. Records showed staff received equality and diversity training. Staff confirmed they had done this training and demonstrated they knew how to treat people equally. One staff member told us, "Yes I did equality and diversity training. I was quite vocal on a couple of subjects. "We have to treat everybody with respect and dignity." Another staff member said, "By giving them their own rights, making sure they have their own voice, listening to them, if they are non-verbal we should find a way like Makaton, flash cards." A manager told us, "Every staff has been trained in terms of how to work with people from a diverse background. When recruiting we try to have people of the same race and we make sure staff are tolerant of other staff beliefs."

The managers and staff explained how they would support people who identified as being lesbian, gay, bisexual and transgender (LGBT). A manager told us, "Every staff has a clear understanding and is well equipped with working with people's sexual orientation. We could have an advocate and do lots of research. If they have the capacity to know what they are doing, we can do a referral to the LD (learning disability) team. We have discussions in the MDT (multi-disciplinary team) who will signpost us to the right professional. Look ahead are coming up with an LGBT policy." A staff member said, "I would go online and study in order for me to understand them to be able to work with them and treat them equally and don't let them feel excluded." This meant staff were aware of equality and diversity.

People's privacy and dignity was promoted. One staff member described how they gave people personal care and managed continence care whilst maintaining dignity. This staff member also explained if a person who used the service needed private time, then staff would not disturb them until the person ready. Another staff member told us, "When person is in their room, if I need to give personal care, I make sure the door is closed. Even if person is in the toilet I close the door but leave it open a little bit, so I can go in and help when needed."

A manager told us that if required a person's 'significant other' could stay overnight. The manager said, "We would not be a barrier. We would look at the person's capacity and needs and the needs of the partner."

Staff described how they promoted people's independence. One staff member told us, "[Person] can put on their clothes themselves. If they need help, then I will help. They can put their own jacket on and this lets you know they want to go out." Another staff member described how one person helped with tidying the house and helped with the laundry. This meant people were assisted to maintain their independence.

Is the service responsive?

Our findings

Staff understood how to deliver personalised care. One staff member told us, "People have different needs and we have to establish their preferences. What we have observed [for one person] is that if someone has a gruff voice this will unsettle [person]. The people [this person] warms to are those that show [them] love." Another staff member said, "It's when you have a particular routine for that individual. We can ask them what they want. First, I have to understand them, know what they want and give them choices. Let them be able to make choices."

A relative told us their family member had access to suitable activities but there could always be more. A local authority professional told us, "I was particularly impressed with the planning and co-ordination of meaningful activities for the [person]." Staff and the managers told us one person had made progress since they began to use the service and was now able to go to places of interest on public buses which had not been possible before. We saw activities included swimming, music, walks in the park, trampolining, football, car rides and trips to the Olympic Park. People had a pictorial activity timetable with their chosen activities for the week.

People's care plans were based on outcomes that could be achieved. Staff described how one person who used the service on admission had been told about all the things they could not do. However, through teamwork and determination, this list had reduced, and it was now about all the things the person was able to do. For example, staff had been told the person would not be able to travel on a public bus but now they were able to for quite long distances.

Care plans were personalised and contained people's preferences. For example, one person's care plan included they liked music gadgets, their stereo and the TV and stated not having these items worried them. The care plan stated, "I would like staff to be hospitable to my family." There was a separate section for each aspect of care with detailed guidance so that staff knew how to assist each person. The care plan sections included personal care, nutrition, community access, physical and emotional health, medical appointments, finances and communication. Care plans were reviewed every two months through keyworking sessions.

We discussed the Accessible Information Standard (AIS) with the managers. The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. A manager told us, "These guys have the right to information the way they can understand it." The managers showed us policies that were available as easy read and pictorial. Records showed that parts of people's care plans were also in an accessible format and contained people's preferred method of communication.

One person's communication care plan stated, "[Person] is non-verbal but makes sounds and can understand Makaton, pictorial signs and now and next. [Person] loves making high pitch noises which indicates good mood. [Person] will hit [their] forehead to communicate to staff that [they] have headache." The care plan also gave details to staff of the signs to look out for when the person was happy, unhappy or in pain and indicated the person would use objects of reference to show what they wanted.

The provider had a complaints policy. The managers told us no complaints had been made since the service became operational. We asked a relative if they had needed to make a complaint and they responded, "No, not yet." The relative told us who they would speak to if they were not happy with the service. Staff were knowledgeable about how to respond to complaints. One staff member explained the process of dealing with a complaint and said, "You have to give them forms to fill and you have to act on it immediately. The main thing is that the person feels satisfied." Another staff member told us, "I would give them a complaint form, so the manager can deal with it."

The provider had an end of life policy and procedure. However, at the time of this inspection people using the service were younger and not anticipated to require end of life care.

Is the service well-led?

Our findings

There was not a registered manager at the service. The manager of the service was in the process of applying to become CQC registered. A relative spoke positively about the management of the service and told us, "Oh yeah, [the management] is alright so any little queries I can tell them. The routine seems to be going smooth. They listen here."

Staff spoke positively about the management of the service. One staff member told us, "I have free access to speak with management. I'm very vocal and I will insist the service remains in a very structured way. I think they [management] are very good. Everybody's been exposed to the same element of training. We work as a team to sustain standards." Another staff member said, "They give us information what we need, put us on training. I feel supported in so many ways."

The managers explained to us the different ways that staff were able to contribute to how the service was run. They told us, "Staff meetings, the company has a suggestion box, daily handovers. We have an open door policy, so they can have access to us all the time. Excellence, trust and aspiration quarterly staff award. The nominations [for this award] go to a panel."

Staff confirmed the provider treated them equally and fairly. One staff member told us, "There is a big emphasis on dignifying staff. They provide you with the tools for development purposes." Another staff member said, "Yes, they treat us fairly." A manager told us, "The company has an equal opportunities policy which is open to everyone regardless of whether they want to use the services or work in them."

The provider had a system of obtaining feedback. There was an easy read pictorial feedback policy, which gave guidance to people using the service in a format that was easy to understand, about the different ways they could have their say on how the service was run. The management team told us they had not yet asked for feedback through a survey from people who used the service. We reviewed the survey form which had been sent out in August 2018 to stakeholders. Questions on the survey included what the respondent felt could be improved in the service. At the time of the inspection the provider was waiting for respondents to return their completed survey, so they could analyse them and make improvements to the service.

The provider had a system of holding monthly meetings with staff. Staff confirmed they attended these meetings and found them useful. One staff member told us, "We have [meetings] every month. I do find them useful." Another staff member said, "They are useful. Primarily they are a forum for a chance to express ourselves." We reviewed the minutes of the two most recent staff meetings. Topics discussed included activities, daily tasks, accommodation and the living environment, medicines, healthcare, quarterly staff award and training. This meant staff could receive regular updates on service developments and make suggestions for improvement.

The provider had a quality audit system to identify areas for improvement. The manager of the service had a monitoring toolkit which they used to audit the quality of the service provided. This system showed the checks that were required on a daily, weekly, monthly, quarterly, six monthly and annual basis. Care staff

completed a weekly health and safety check and a monthly living standard check which was checked by the manager during their monthly health and safety check. We saw the health and safety audit carried out on 2 August 2018 noted PAT testing needed to be completed by the end of September 2018. Records showed this action was completed and PAT testing was carried out on 27 September 2018. Medicines were audited each month by the manager which highlighted any issues and the staff member responsible who would be monitored for two weeks for their competency in medicine administration. We reviewed the medicine audit completed on 26 August 2018 and saw no issues were identified.

The provider carried out regular quality audits. We reviewed the audit which was carried out by the head of safeguarding and quality on 27 September 2018. This audit looked at the service's compliance with CQC's key lines of enquiry. We noted the recognition of improvement in one person's quality of life due to being able to take part in activities and trips out. Actions identified included providing training in Makaton for the staff team to aid communication with people using the service. Progress on achieving identified actions were documented and we noted the provider's learning and development team were contacted on 1 October 2018 to commission the above training.

The service worked in partnership with other agencies in order to improve the service. The management team told us they took it in turns to attend the providers forum. They said, "[The forum is] used to share good practice and Newham gives information on what they expect, and we discuss training and work with BILD (the British Institute of Learning Disabilities)." One of the managers told us, "We do joint activities with MIND and tap into what other organisations are doing to enhance the activities for [people who used the service]." Another manager said, "We are working towards becoming an accredited centre for positive behavioural support to have coaches within the organisation and in time to be able to give training to other organisations."