Lifeways Inclusive Lifestyles 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?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on Tuesday 20 and Wednesday 21 June, 2017. The inspection was announced.

Lifeways Inclusive Lifestyles Ltd is registered to provide domiciliary care to people who have learning disabilities and complex needs. They provide support to seven people in two separate shared houses. Each person within the shared house has their own separate tenancy agreements and are supported by staff 24 hours a day.

A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 registered manager had a number of different systems in place to assess and monitor the quality of the homes, ensuring that people were receiving safe, compassionate and effective care. Such systems included weekly, monthly, annual audits and the relevant health and safety and infection control checks.
We have made a recommendation to the provider about seeking and gathering the views of others as a way to maintain and improve the standard and quality of care being provided.

Staff were knowledgeable around the area of safeguarding procedures and knew how to report any concerns. All staff we spoke with were able to explain who they would report their concerns to and what actions to take. Staff had completed safeguarding training and there was a safeguarding policy in place.

All care files contained individual care plans and risk assessments which were regularly reviewed and updated in order to minimise risk. Care plans were person centred and contained a detailed amount of information in relation to a person's wishes, choices and preferences.

Risk assessments were in place for all seven people who lived at the two shared homes. The assessments offered key information about significant areas of risk and how such situations would need to be managed for the safety of everyone living in the homes.

There was a significant amount of emphasis on person centred care and support for people. 'Person centred' care means that the service tailors its approach to the care which needs to be provided to suit the needs of the person and not the needs of the organisation. People were supported to be independent and were encouraged to actively manage their own lives as much as possible.

Recruitment was safely and effectively managed. Staff personnel files which were reviewed during the inspection demonstrated that effective recruitment practices were in place. This meant that all staff who were working at the homes had suitable and sufficient references and disclosure and barring system checks (DBS) in place. DBS checks ensure that staff who are employed to care and support people are suitable to

work within a health and social care setting. This enables the registered manager to assess level of suitability for working with vulnerable adults.

Medication was administered safely by staff who had received the appropriate training. Medication records were accurate, medication audits were conducted on a weekly basis, systems were in place to order repeat medication, dispose of medication as well having the correct storage procedures in place.

Accidents and incidents were routinely recorded on an internal database system. These were discussed as part of team meetings and routinely analysed as a measure to explore if lessons could be learnt.

The registered provider operated within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We were provided with information in relation to capacity assessments and processes which were in place to make decisions in a person's best interest. People were supported to have 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.

Staff expressed how they were fully supported in their roles; they had completed all mandatory training as well as specialist training in order to fulfil their roles effectively. Staff received regular supervisions and annual appraisals were being completed as well as regular team meetings taking place.

People were supported with their nutrition and hydration needs. Staff supported people to make their own decisions with the food and drink; people were involved with the preparation of food and were encouraged to make choices about the different types of food and drink they wished to be purchased.

Staff were caring towards people they were supporting and provided respectful, dignified and compassionate care. Relatives we spoke with told us they felt the staff were kind, caring and provided good quality care.

There was a complaints policy in place and people knew how to make a complaint. There was evidence of complaints being submitted and responded to in line with the organisations policy.

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 familiar with safeguarding and whistleblowing policies.

Satisfactory recruitment checks were carried out.

Medication systems were safely managed.

Care plans contained up to date information about people's support needs and regular reviews were taking place.

Is the service effective?

Good

The service was effective.

Sufficient and suitable training was being provided to all staff.

Regular supervisions were taking place to support professional development.

The service was working in accordance with the principles of The Mental Capacity Act 2005 (MCA)

Is the service caring?

Good

The service was caring.

Staff were familiar with the support needs of the people they were caring for.

Positive relationships had been established with external healthcare professionals.

Relatives were satisfied with the care being provided.

Is the service responsive?

Good

The service was responsive.

Complaints processes were in place although relatives expressed that the 'day to day' concerns were not responded to.

People's care plans were person centred and contained a significant amount of information in relation to their needs, wishes and preferences.

Is the service well-led?

Good

The service was well-led.

The registered provider needs to explore different methods to obtain feedback from relatives and people using the service.

There were clear and robust systems in place for auditing (checking) service delivery and the care which was being provided.

The culture was that of an open, transparent and supportive one.

Lifeways Inclusive Lifestyles 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 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 20 and 21 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available on the day.

The inspection team consisted of two adult social care inspectors and an expert by experience on the first day of the inspection and one adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we reviewed the information which was held on Lifeways Inclusive Lifestyles Ltd. This included notifications we had received from the registered provider such as incidents which had occurred in relation to the people who were being supported at the two locations. A notification is information about important events which the service is required to send to us by law.

A Provider Information Return (PIR) was also submitted and reviewed prior to the inspection. This is the form that asks the provider to give some key information in relation to the service, what the service does well and what improvements need to be made. We also contacted commissioners and the local authority prior to the inspection. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the service manager, team leader at one of the shared houses, two members of staff and five relatives by telephone.

We also spent time looking at specific records and documents, including four care records of people who lived in both shared houses, five staff personnel files, staff training records, medication administration records and audits, complaints, accidents and incidents and other records relating to the management of the service.

Good

Is the service safe?

Our findings

All relatives we spoke with had positive comments to make in relation to the safe care which was being provided. One family member we spoke with said "They (staff) go over and above to make sure things get done and that (relative) has a good quality of life". Another relative we spoke with said "The staff are supportive and I feel (relative) is safe and well cared for in every aspect of their care".

The four staff records which we reviewed on the first day of the inspection evidenced the robust systems which were in place to ensure the staff who were recruited were suitable to work with vulnerable people. The registered manager retained comprehensive records relating to each staff member, full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to commencing their post. The appropriate employment checks had been completed before staff began working at the service. Application forms had been submitted, confirmation of identification was evidenced in files, suitable references had been obtained and Disclosure and Barring Service (DBS) checks had been suitably carried out.

Relatives informed us that there was enough staff to provide the support needed by people using the service and commented that staff who provided the support had been employed for a long period of time. This ensured consistency and ensured that staff were familiar with the care needs of the people they were supporting. 'Out of hours' on call arrangements were in place to ensure sufficient support was available to people and staff in the event of an emergency. In the event of an emergency staff would firstly contact a team manager who would ensure appropriate action had been taken. Staff expressed how the 'on call' system provided extra support if further assistance was ever needed such as over the phone support or advice.

Accidents and incidents were recorded and monitored at the service but also updated on an internal database. The registered manager would analyse the accidents and incidents and explore whether any remedial action needed to be implemented. 'Lessons learnt' were then discussed at regional team meetings as well as being communicated at staff meetings.

Risk assessments provided staff with essential information in relation to specific support which needed to be provided and how to manage potential risks. For example, we saw how people were being supported when their behaviour became particularly challenging. The risk assessments which were in place enabled staff to appreciate what signs and triggers to look out for and what control measures needed to be put in place. This demonstrated that risk was being managed and the safety of the people was being maintained.

There was an adult safeguarding policy in place. We spoke with staff about their knowledge and understanding of safeguarding procedures and they were clearly able to describe how to report any concerns. The majority of staff had completed safeguarding training and were familiar with how to make safeguarding referrals. Records confirmed that appropriate safeguarding referrals had been made to the local authority when required. This helped to ensure people were protected from the risk of abuse.

Medication systems and processes were being safely managed. Medication was only administered by staff who had received the relevant training and medication was stored safely, administered appropriately and disposed of correctly. Locked cabinets were bolted to the walls of the main office which contained all medications as well as a fridge which was used for medications which needed to be refrigerated. Room temperatures as well as fridge temperatures were monitored on a daily basis; this ensured that the medications were being kept at the correct temperatures in accordance with the pharmacy guidance.

Weekly and monthly medication audits were being carried out to ensure that medication processes were being safely managed. Medication administration records (MAR) indicated that people had been administered their medication as prescribed. We reviewed MARs for three people and we could see that all totals corresponded to the totals recorded on the MAR sheets. Each medication file contained a photograph of the person in receipt of the medications, as well as a PRN protocol ('as and when needed' medication). 'As and when needed' medication protocol clearly outlined when the medication could be given and the amount of medication which could be administered.

There was evidence of health and safety audits being conducted to ensure the people who lived at the services were safe. Audits which were conducted included fire protection and prevention, monitoring of water temperatures, fire evacuation audits as well as infection prevention control audits. Records also confirmed that gas appliances and electrical equipment complied with statutory requirements.

The annual fire risk assessment we reviewed did highlight several outstanding actions which hadn't been completed within a six month timeframe stipulated. This was discussed with the registered manager who confirmed that several of the intermediate actions were still being reviewed and followed up. Following the inspection, the registered manager confirmed that actions which had been identified were being addressed and would be completed within an eight to twelve week time frame.

Good

Is the service effective?

Our findings

Relatives were asked if the care being provided was effective. Some of the comments we received included "The team around (my relative) know and care for (my relative) they are an amazing team". Another comment included "The staff have been absolutely brilliant".

We asked staff about the training they received in order for them to fulfil their roles adequately. We were provided with the most up to date training matrix during the inspection and it was evident that the majority of staff had completed all the organisations mandatory training.

Mandatory training which staff needed to have completed as part of their role included food safety, health and safety, infection control, manual handling, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) adult safeguarding and medication knowledge and awareness. Training was a mixture of e-learning and classroom based courses. We saw that each staff member had a file with all of their certificates stored and the training matrix showed that 90% of all staff had completed all of their training. One staff member told us, "The training is really good, I really enjoy learning"

We also saw evidence of specialist training being delivered for staff as a way of enhancing and equipping staff with the necessary skills. Such training included autism, epilepsy, diabetes, person centred working and positive behaviour support (PBS) training. Newly appointed staff were also required to complete an induction aligned to the principles of the Care Certificate. The Care Certificate, which was introduced by the Government in 2015, is a set of minimum standards that social care and health workers are required to meet in their daily working life. This is designed to be completed within 12 weeks of staff starting work and signed off by a competent staff member (such as a senior or manager) once completed.

People were appropriately assessed from the outset, risks were identified and regular reviews were taking place. Those who lived at the homes were supported and cared for by trained staff who were familiar with their needs and wishes. The majority of relatives commented they were fully involved in the care and support which was provided and that they received regular contact with the staff from the shared homes. However, one relative expressed "Parent input is not asked for; things are done without any involvement".

Supervisions and appraisals were regularly carried. Supervisions are regular meetings between the staff member and their manager to discuss any issues which need to be addressed in a one to one setting. Discussion may include on- going training needs, professional development, concerns with other staff or people living at the home, annual leave, sickness as well as other areas of discussion. All staff expressed that they felt supported and valued in their roles .Staff explained how they felt supported in their roles, one staff member expressed "I'm supported by all managers, any issues are listened to and I feel I'm valued" and another staff member commented "Yes, I feel really supported actually".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (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.

People in community-based settings, such as extra care require an application to the Court of Protection (CoP) to ensure that any deprivation of their liberty is being done within the law. At the time of the inspection there was no one subject to an authorisation by the CoP. All staff and management had a good understanding of the legislation surrounding the MCA and the associated DoLS. The provider had ensured that 'Best Interest' meetings had been carried out and people were not being unlawfully restricted. This demonstrated that the provider was aware of their roles in relation to the MCA and the legislation underpinning the act.

Those living at the service had access to external health professionals and there was evidence of health checks taking place. There was a 'Health Appointment Record' found in each person's care file which provided information about specific appointments such as dentist, optician, occupational therapist, GP appointments.

Appointments were scheduled into people's weekly activity plans and staff were allocated to help support that person to attend the appointments. We saw that staff had completed the necessary records when they returned from the appointment as to ensure that all staff were updated with any changes to the persons health and well-being.

People who lived at the home were encouraged to be actively involved with food and drink purchases which took place each week and it was evident from our discussions with staff that they were familiar with people's likes and dislikes. Weekly meetings took place to ensure people living at the home had full involvement with weekly menus and to also ensure that choice and preference was being supported. We saw that staff had made necessary referrals for specialist advice and support to ensure people's dietary needs were appropriately met.

Good

Is the service caring?

Our findings

Each of the relatives that we spoke with commented on the caring nature of the staff and felt that their loved ones were well cared for. Some examples of the feedback we received included, "This is the first place where all of the family have been delighted with the support, we haven't had this in the past, I can't say enough about how happy we are as a family" Another relative expressed "My family member is treated well and kept safe" and "They have included us at all levels I can't say enough about how amazing this organisation we have been really lucky to have found this organisation".

There was a lot of person centred detail in each of the care files which provided staff with essential information about the people they were caring for. Relatives (where legally allowed to do so) had been involved in care planning processes or via the best interest process. This is where people cannot consent to the care being provided for themselves. Such information included personal details, relationships and social contacts, weekly activity planners, health appointment records, weight charts, communication passports as well as individual care plans, additional care plans and risk assessments which were regularly reviewed and updated.

Positive relationships had developed between people and staff. Staff were familiar with the people they were supporting and were able to discuss specific support needs, likes, dislikes and preferences. Staff promoted a culture of warmth, kindness and compassion and over the course of the two day inspection and it was evident that the staff were committed to delivering safe, effective and compassionate care.

Care plans demonstrated that family members and people using the service had been involved in the care which needed to be provided. Regular reviews were taking place and there was up to date information documented in care plans as well as risks being updated. The level and detail of information found in the care records informed staff of the support which was needed, how the support needed to be provided and if there was any risk which needed to be managed.

Staff and relatives we spoke with explained that people living at the homes were always treated with dignity and respect. People being supported by the service had many choices about different aspects of their care such as weekly activities, what food and drink they wished to purchase, what clothes they wishes to wear and what time they wished to go to bed of an evening. One relative expressed "They (staff) give (relative) respect and treat (relative) well". Staff expressed genuine, compassionate care when discussing the people they support and it was evident that their needs and choices had been communicated amongst the team.

The provider worked in partnership with external healthcare professionals as to ensure that those living at the two homes were receiving safe, caring and compassionate care. There was evidence of support being provided by occupational therapists, speech and language therapists (SALT) opticians, dentists and GP's. We checked to see if people had information made available to them in a way which they could understand. We saw that the provider had made various 'easy read' material to help support people's understanding. These included complaints leaflets, 'guide to your service' and support plans.

Good

Is the service responsive?

Our findings

Not all people who lived at the homes were able to directly communicate their level of involvement in their own care during the inspection. However, it was evident from observations, discussions with staff and relatives that people had a good amount of involvement in the care which needed to be provided. We saw examples which clearly evidenced that a person centred approach was central to the care being delivered. 'Person centred' care means that care is provided based on the needs of the people using the service.

We asked relatives if their family member received this person centred care. Relatives expressed "They have been absolutely brilliant". Another relative commented "Staff are supportive and I feel (relative) is safe and well cared for in every aspect of their care" and another comment included "They are polite and caring and professional, they work really hard".

It was evident from the care records we reviewed that a good level of information was captured about the person before they began receiving the support from the provider. The pre-admission assessment and amount of detail which was gathered, provided staff with a significant amount of information about the level of person centred care which needed to be given and how this care and support was to be delivered.

Each care record contained detailed information in relation to personal history, likes and dislikes, social activities, individual support needs and risks. Where appropriate relatives had been involved in the assessment process and we saw evidence to suggest that relatives had continued to be involved in the care being provided. One relative explained how they had 'full involvement' in the care which was delivered from the outset and another relative expressed, "I'm involved at every stage of (my relatives) support". Having a suitable amount of support from relatives meant that the care and support being provided was relevant and appropriate to the needs of the person.

Staff explained that for those people who had limited verbal communication, Makaton and picture exchange therapy (PECS) was used as a way to communicate and interact with people effectively. Makaton is a way for people to communicate using hand gestures and signals and PECS allowed people and staff to communicate with each other using pictures and images. Staff explained that being able to use such techniques enabled staff and people who lived in the homes to remain involved in their care, feel listened and responded to and helped encouraged people to make choices and decisions.

Care plans contained specific information around people's preferences and support needs. For example, one person's care plan stated 'please don't rush me, I like to be woken up gradually.' Whilst another stated, 'I like to make a choice from two items of clothes, please hold them up for me to choose.' And 'knock on my door and greet me gently.' We saw another support plan for a person who had a specific medical disorder. We saw how their support plan made particular reference to the medical disorder, how the person needed to be supported, what the staff needed to do in order to support the person and how the support would benefit the person.

We saw care plans for areas of care which included choices, health and well-being, everyday tasks,

managing money and behaviour. Care plans were regularly reviewed and records were being updated accordingly. This provided staff with the relevant information to help ensure people received the care and support they needed. Each person who lived at the home had an up to date care plan in place and the relevant risk assessments. Care plans included 'choice and control', 'health and well-being', 'living safely', 'family and relationships' and 'everyday tasks'. Care plans were reviewed and updated with relevant information and significant changes. It was evident throughout the inspection that staff were familiar with the different support needs of the people they were caring for.

We saw evidence of 'annual reviews' taking place. Such reviews took place with managers, relatives and people living at the homes. There were discussions around the care which needed to be provided, a review of the care being provided, any new risks which need to be managed and 'what is important' to the person at that moment in time. This helped ensure that the care and support being provided to people remained appropriate to meet their needs.

There was mixed responses in relation to the activities which were delivered at both homes people lived in. We saw evidence of activities taking place at local parks, people going for meals, going to the local pub and sensory rooms. However relatives expressed "There are not enough activities" and "The activities seem limited" There was no designated activities co-ordinator in place but staff commented that "activities were largely tailored to the needs of the individual". All preferred activities were listed in the individual's care plan goals such as "visits to the beach, football matches, swimming and out for picnics". When we discussed activities with staff, they informed us that they tried to support people with as many of their preferred activities as possible.

The provider had a complaints policy and processes in place. The procedure for making a complaint was clear and we saw that all complaints had been appropriately documented and investigated in line with the provider's complaints policy. There had been two formal complaints in the past 12 months. We reviewed one of the complaints and saw that all guidelines set out in the registered provider's complaints policy had been followed.

People we spoke with provided us with mixed responses in relation to making complaints and raising concerns. One relative expressed "When I had an issue I rang directly to the home and spoke to staff, they were little issues but they got sorted out" however some of the more negative comments included, "If you voice your complaints, not much happens I don't blame the staff, I don't think they are listened to or supported by the company" and "Everything that was asked for regarding improvements to the setting and spending money have taken years to get done".

There was evidence from action plans and team meeting minutes which we were provided with that certain aspects of the environment have been identified as areas of improvement. The environment itself raised some concerns amongst the relatives we spoke with as part of the inspection. Relatives expressed that certain aspects of the environment needed to be refurbished such as the kitchen area, laundry room, carpet on the stairs, re-decoration of the bedrooms as well as needing to replace window blinds. Relatives expressed that these concerns have been raised with the managers but 'nothing much happens'. When we discussed this with the registered manager we were informed that 'home improvements' were being looked into, that some improvement had already taken place but they were aware that further refurbishment work was still required.

Each person who lived at the home had an up to date care plan in place and the relevant risk assessments. Care plans included 'choice and control', 'health and well-being', 'living safely', 'family and relationships' and 'everyday tasks'. Care plans were reviewed and updated with relevant information and significant

changes. It was evident throughout the inspection that staff were familiar with the different support needs of the people they were caring for.

Care records also contained important information in relation to day to day care needs, medication profile, day and night routines, 'goals', activities, missing persons information, 'hospital passport', health appointments record, accident and incident log, personal emergency evacuation plans (PEEP), support plan reviews and easy read information.

Good

Is the service well-led?

Our findings

From the observations which took place and also from the relevant discussions held with staff and relatives over the course of the two day inspection, it was evident that an open and supportive culture was promoted and a person centred approach to care and support was being provided.

There was a registered manager at the time of the inspection. The registered manager had been in post since October 2016. The registered manager was aware of their responsibilities in relation to their regulatory requirements. Statutory notifications were submitted in accordance with regulatory obligations. As the registered provider had only been registered with the CQC since 2016, no previous ratings had been awarded.

We saw evidence of questionnaires being circulated to families and carers as well as annual satisfaction surveys being sent to people who were being supported. We saw the most recent questionnaires, which had been sent out in 2016. However, only 4% of surveys were returned, the results were particularly positive in relation to care planning and people being treated with dignity and respect; however the response rate did not provide an overall, proportionate view of the standard and quality of care being provided.

We recommend that the registered provider explores alternative methods of seeking and gathering the opinions of relatives and carers. Gathering a more balanced view of the care being provided will help to identify what works well but will also identify improvements which may be needed for the benefit of the people being supported.

Staff we spoke with were very complimentary about the registered manager, one staff member expressed "(registered manager) is the best manager I've ever had, so supportive and knowledgeable, we all work together as a team so the best quality care is given" and one staff member expressed that the team leader at one of the houses was "very supportive" with another staff member "(Team leader) is great". However, the feedback from relatives was less positive. One relative commented "You never see or hear from the main management, it's all left to the senior person at the setting and although (team leader) is really good (team leader) is overwhelmed with work" and another comment included "The senior management are non-existent".

All of the staff we spoke with told us that they 'loved' their jobs; they enjoyed supporting and caring for people as well as being able to watch them grow as individuals. One staff member said, "We try and empower them as much as we can" with another member of staff expressing "The care people receive is second to none; they progress so much and are well supported".

We saw evidence of satisfaction surveys being circulated to families and carers. We saw the most recent questionnaires, which had been sent out in 2016. However, only 4% of surveys were returned, the results were positive particularly in relation to care planning and people being treated with dignity and respect; however the response rate did not provide an overall, proportionate view of the standard and quality of care being provided.

We recommend that the registered provider explores other methods of seeking and gathering the opinions of relatives and carers. Gathering a more balanced view of the care being provided will help to identify what works well but will also identify improvements which may be needed for the benefit of the people being supported.

Effective quality assurance systems were reviewed during the inspection. Audit systems which were in place ensured that the health, safety and well-being of those living at the home was well managed. We saw evidence of medication audits, care plan audits, and health and safety audits as well as the regulatory certificates being in place for gas safety and electrical equipment. There was an up to date Business Continuity Plan (BCP) which contained all relevant contact details of both internal and external services and agencies. The BCP supports staff to make important decisions and to contact the necessary people in the event of an emergency.

We found evidence of regular staff meetings taking place. Team meeting discussions included staff training, safeguarding concerns, activities, updates on care plans and risk assessments as well as home improvements and managerial updates.

Communication and recording systems which were in place were effective. It was evident from the inspection that the staff team worked well together and were continuously discussing the care needs of the people they were caring for and supporting.

The registered manager regularly reviewed internal reports which showed level of compliance across the organisation in relation to a number of different areas such as training, audits and action planning. For example, the registered manger acknowledged that training compliance was lower than what was expected. This information then enabled the manager to then focus their attentions on the training requirements of staff. We saw that the level of training compliance had risen and staff have completed the necessary training required for their roles.

There was an on-going action plan which had been produced and the service manager was responsible for completing any actions which were identified.

Team leader meetings took place every six months, 'manager's briefings' took place weekly and there were also regional monthly managers meeting with managers from different parts of the organisation. The aim of these meetings was to reflect over current and previous practices, any lessons which need to be learnt and how to make improvements. Meeting minutes we reviewed showed evidence of discussions taking place in relation to safeguarding, accidents and incidents, health and safety and changes to peoples support needs.

The registered provider had up to date policies and guidance in place for staff to familiarise themselves with. Such policies included safeguarding, whistle blowing, equality and diversity, health and safety and medication. When we discussed such policies with staff, they evidenced understanding and awareness. Having such policies in place ensured that there were clear processes and guidance available for staff to follow but to also ensure that they were aware of their responsibilities as staff members.