Care Quality Commission

Access Community Services Limited

Access Community Services Limited

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

Access Community Services Limited is based in Southport, Merseyside and provides personal care and support to people who have learning disabilities, physical disabilities or mental health conditions. The service provides care and support to people living in their own homes including 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This was an Announced inspection which took place over two days on 20 and 21 August 2018. The service was supporting 45 people within supported living and 52 people in the community; 36 of the total 97 individuals received support with personal care.

We last carried out an inspection of this service in November 2017. This had been a 'focussed' inspection where we looked specifically at previous breaches of regulations. We found there had been overall improvements but the service still required to improve some management systems as the provider's action plan had not been fully met and there were areas that still required development and implementation. The service was rated as 'Requires improvement' for the second consecutive inspection.

On this inspection we found continued improvement and more consistent and sustained service delivery. Managers had continued to develop management systems to assess and monitor the service ongoing and the remaining breach of regulations regarding the governance of the service had been met. The registered manager could evidence a series of quality assurance processes. There was a clear management hierarchy and we saw that new ideas and service improvements were effectively developed and communicated.

We rated the service as Good.

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.

We visited two of the supported living houses which were staffed by the care agency. We also spoke with people who were receiving support at their own homes. The observations made and feedback we received evidenced people were getting good support. External professionals involved in peoples care also gave positive feedback which gave further evidence of a good service.

We found medicines were administered safely. Medication administration records [MARs] were completed in line with the service's policies and good practice guidance. We pointed out some anomalies in one 'house' we visited concerning safe storage of medications and staff knowledge regarding covert administration of medicines [medicines given without a person's consent] and both issues where addressed by managers.

There were arrangements in place for checking the care environment to help ensure this was safe. These arrangements included regular checks and audits by house managers which were supported by health and safety audits by senior managers.

People using the service, relatives, professionals and staff told us they felt the culture of the organisation was fair and open and supported good care and support for people using the service.

People we spoke with said they felt safe with the staff from the agency and the support they received. We were told that if any issues arose they were addressed by the managers.

We saw that any risks to care provision had been assessed and there were fully developed plans in place to help ensure they were kept safe. 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 in place to ensure staff were suitable to work with vulnerable people. Appropriate applications, references and security [police] checks had been carried out.

The staff we spoke with clearly described how they recognised abuse and the action they would take to ensure actual or potential harm was reported. All the staff we spoke with were clear about the need to report through any concerns they had. We reviewed past safeguarding investigations and it was established that the agency had followed procedures and liaised well with safeguarding authorities. 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 people's consent to care was recorded. The service worked in accordance with the Mental Capacity Act 2005.

Feedback from people and their relatives 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. We found that house managers had been left out of the formal supervision process; managers said this would be reviewed and formalised. Formal qualifications in care were offered to staff as part of their development.

Local health care professionals, such as the person's GP and the Community Mental Health Team [CMHT] were involved with people and staff from Access Community Services liaised when needed to support people. This helped ensure people received good health care support.

Staff could 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 in expressing concerns and complaints. Issues were dealt with and the service was responsive to any concerns raised. An issue raised on the inspection was dealt with appropriately with the services complaints procedure.

The registered manager and the two deputy managers could 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. It was clear that the service was meeting standards outlined in current good practice guidance including 'Registering the Right Support'.

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 service's 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 helping 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?

Good

The service was effective.

The service worked in accordance with the Mental Capacity Act 2005. Care planning contained enough detail regarding people's decisions around key issues.

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 appointments with health care professionals such as GPs and district nurse teams to help support people in their own home.

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 commented positively on how the staff approached care.

Staff 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.

People in receipt of end of life care were assessed and appropriate measures were in place to provide support.

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 a clinical manager and other service managers in a clear management structure.

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

Care Quality Commission

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 two days on 20 and 21 August 2018. We announced the inspection to ensure we could get consent to speak with and visit people in their own homes. 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 information prior to 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.

During the inspection we visited two supported living houses and spoke with five of the people who received care from Access Community Services Limited. On the second day of the inspection we visited the central offices of the service. We also contacted by telephone and received feedback from another two people who used the service and nine relatives.

We spoke with eight staff including care/support staff, two senior managers for the services and the registered manager. We looked at the care records for three of the people being supported, including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service such as safety audits and quality audits.

We spoke with three health and social care professionals who gave us feedback about the service which was wholly positive.

We spoke with eight staff including care/support staff, two senior managers for the services and the registered manager. We looked at the care records for three of the people being supported, including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service such as safety audits and quality audits.

Good

Is the service safe?

Our findings

People we spoke with who were being supported by Access Community Services told us they felt safe and were supported well. One person, in supported living accommodation, said, "I've not been here long but I've settled really well; staff are very approachable and support me well." Relatives also felt the service provided safe support. Some comments were: "I feel safe and secure that [person] is well looked after by the carers," "Staff make me reassured and I trust them," and "You can relax and feel safe knowing that [person] is in good hands."

There were two relatives of people being supported at home, who told us they had experienced some issues around safe care such as staff not being aware of some care needs. We discussed these with the service's manager for domiciliary care, who told us they were fully aware of the issues and these were being discussed on an ongoing basis so that agreements could be reached regarding changing care needs.

We reviewed medication management by looking at the policies and procedures used by the service as well as reviewing them with people we visited. People we spoke with told us they were happy with the way they were supported with their medication. When care staff administered medicines, we were told these were on time and staff were competent. One relative commented that staff had carried out a good assessment of medication support with clear aims to get their relative to eventually support themselves and administer their medication.

Staff told us that all medicines were administered by designated staff members who had received the required training. 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 manager or a team leader following initial training. We saw an example of these assessments for one of the staff we spoke with. One staff member told us, "The training is thorough; I felt very confident when I started to administered medicines on my own.''

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 fully to show that people had received their medication.

Some people were on medicines to be given when needed [PRN]. 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. Each person had an overall 'medication care plan' which was detailed and informed care staff of any individual preference or risk factor. The plans we saw showed that people had been consulted appropriately.

Medication was stored safely in the supported living accommodation we visited. We did observe in one 'house' that a person's thickening powders [used to thicken drinks for people with swallowing difficulties] was not stored appropriately and could possibly be accessed by another person living in the house. This was rectified immediately. The registered manager assured that audits carried out in the future would include

reference to storage of thickening agents. There were no other people being supported who had been prescribed thickening agents.

The service's medication policy was seen and covered all areas of medication administration. We discussed the policy's reference to the use of medicines given 'covertly'; without people's knowledge but in their best interests. This was only briefly explained in the policy document. Following our visit, the registered manager sent us a revised statement which was much more detailed and would be included in future staff updates.

People requiring support at home had any risks identified and recorded with an active plan of intervention and support if needed. The care records we saw identified risks had been assessed. For example, the support plan for the person who had difficulty swallowing had a detailed assessment regarding the risk of chocking. If people needed support with their mobility a 'moving and handling' assessment had also been recorded and these were very detailed and easy to follow. People had been consulted with the assessments. The assessments helped ensure people were kept safe.

Immediate environmental risks were also assessed. This had been an issue on previous inspections in which inadequate monitoring of supported living houses had left people exposed to potential risk. We found house managers and senior managers had improved the auditing processes so that environmental hazards such as fire safety was now adequately monitored. We saw records were up to date and covered environmental risk such as hot water checks. The risk of falls from heights with respect to windows above ground floor was adequately monitored in both houses we visited; managers advised they would ensure ongoing monitoring of window restrictors would be included in all audit tools.

Staff input was agreed depending on assessment and funding and people's individual care needs. Feedback from people was positive in that staffing was relatively stable and consistent. In both supported houses we visited the staff teams were settled and reported allocated hours for support were met. One relative in the community reported, "They are good at their job and have had the same carers for 15 years." Another relative reported they were very reassured that staff were settled and consistent. In one example we observed very good rapport between one person and their key worker who had provided support over a long period and knew the persons care needs very well.

There were thorough recruitment processes to ensure staff were suitable to work with vulnerable people. We looked at 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. We spoke with staff who told us they felt the service had been thorough in their recruitment.

All 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 the staff we spoke with were clear about the need to report any concerns they had. The agencies policies were up to date, clear and inclusive considering local authority safeguarding protocols. A new member of staff reported they had received a recent training session, as part of their induction, covering safeguarding and recognition of abuse.

An 'easy read' guide was available on safeguarding and was issued to people using the agency and relevant others. Managers could talk about past safeguarding incidents. In these examples the agency worked well with the Local Authority and police if needed. 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 in the agency office.

Accidents and incidents were recorded and monitored by the service. The PIR for the service told us, 'We've had five incidents in the recent period, two regarding service user challenging behaviour and three falls. These were investigated and correctly acted upon. Robust contingency plans were in place to ensure the service can continue to operate effectively and safely during incidents'. We saw examples of these which were also discussed at management meetings. Each accident or incident had been followed through individually and analysed so that any lessons could be learnt.

Good

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 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The people we spoke with on the inspection varied in their capacity to make their own decisions regarding their care and treatment. We saw care files where people had signed to say they consented to specific care and had been consulted when assessments had been undertaken. People who could express an opinion told us that when their care needs were being assessed the staff took their time to ensure the final care package or care plan had been agreed and consented to.

One person we reviewed, with the relative present, explained how the staff had carefully assessed their ability to manage their own medications and had devised a plan of care to support them with this which considered their ability to understand and consent to the plan. The care records we saw showed that staff used a standard assessment tool to assess people's ability to understand and consent when making individual decisions.

We saw that staff had received training on the principals of the MCA and this was included as part of new staff induction. The registered manager and deputy understood that the legal process involving decisions to do with people's mental capacity were managed through the Court of Protection if required. They were also able to discuss examples of relatives who had Lasting Power of Attorney to manage their relative's affairs in their best interest.

We received positive feedback from people being supported by Access Community Services. They said the quality of the service was good and commented that staff were very competent. Comments included; "Excellent service, just what [person] wants," "Absolutely knowledgeable" and "Staff are aware of [person's] needs and seems to know what they are doing."

Communication between, people being supported, staff and senior management was effective. All the people we spoke with, including relatives 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 there was mandatory training for all staff in health and safety and fire awareness, first aid, medication, safeguarding, Mental Capacity Act 2005 and infection control. Also, staff were assessed individually for further training dependant on their immediate role in moving & handling, epilepsy awareness, diabetes and food hygiene. We saw training records confirming this.

We spoke with two staff who had undergone the induction course when starting work at Access Community

Services. They advised us that this had been thorough and well-paced with periods of regular 'shadowing' of more experienced staff to support them in developing their role. New staff also had access to the 'Care Certificate' which is the governments recommended standards for new staff induction; ten staff were undergoing this.

Staff were encouraged to work towards diploma qualifications in Health and Social Care. We had positive feedback from staff who said the training provided and support offered by the service was good. 51% of care staff employed had a standard qualification such as NVQ [National Vocational Qualification] or Diploma in Health and Social Care. This was confirmed by records we saw.

Staff told us there were support systems in place such as supervision sessions and staff meetings. We were told; ''We are supported well. Managers are very accessible if we need any support.'' We reviewed some supervision records and discussed the fact that house managers were missing from formal supervision in terms of records; the registered manager advised this would be addressed.

We saw, from the care records that local health care professionals, such as the person's GP were liaised with when necessary. We spoke with three health and social care professionals during the inspection who gave very positive feedback regarding the effectiveness of the service. A member of the Community Mental Health Team [CMHT] told us the service supported some very challenging people who had complex care needs. We were told staff often go 'above and beyond' in terms of the support they offer. A social worker was carrying out a review of supported living in some of the houses in Lancashire and told us, 'They are very good. There are no issues – staff support people really well."

Some of the people receiving care by Access Community Services needed support with their meals. This ranged from preparing a meal to assisting with shopping. One person told us, "I go shopping and staff come with me so I can get food in for meals."

Good

Is the service caring?

Our findings

We received positive feedback from people being supported and their relatives regarding the caring nature of the staff. Comments we received included, "They are kind and caring people," "They are caring people and treat [person] with respect," "They are very friendly with [person]," "They are very caring" and "They are caring and interested in [person]."

We could observe how staff interacted with people they were supporting. We saw examples of genuine concern and interest by staff. Staff spoke warmly and positively about the people they were supporting and were very knowledgeable when discussing people as individuals.

This was supported through the service's management approach and training which helped emphasise people as individuals. The PIR stated, 'Staff are knowledgeable about dignity, diversity and human rights, including what to do to ensure people receive the care they need for a variety of diverse needs. We are members of Dignity in Care. Staff put high value on people's needs to be treated with dignity and respect in all their practices'. We were shown a comment form a stakeholder survey by a professional involved with the service which said, "Staff are professional, supportive and person centred, they provide interesting activities of service user choice and develop their skills in everyday living."

In one interaction it was clear the staff and person they were supporting had developed a good understanding over a long period of time and the trust and rapport was very evident. The relative reported that the consistent approach and relationship developed had helped the person to grow in confidence. In another example a person receiving support towards the end of their lives was seen to be relaxed and at ease with their staff support. The staff member spoke warmly and had a good knowledge of the person's care needs and how these should be met.

At the service's office we saw there was a 'drop in' facility for any of the people being supported to use. Managers reported this gave a focus for any person who might feel isolated and wanted company or more social contact. We saw people visiting this facility and interacting with staff and other people. There was information posted about local events and support groups such as local advocacy contacts. Some of the information was in different formats such as easy read formats to make the information more easily accessible.

Care files referenced individual ways that people communicated and made their needs known. We also saw examples where people had been included in the care planning, so they could see and play an active role in their progress. There was reference to the way individuals communicated and how this could be facilitated. For example, one person who did not communicate verbally, had a care plan describing how they express pain or when they were upset.

Information was kept confidential and maintained safely. We did notice in one supported living house a risk that some information pertaining to a person's health care could be accessed by the other person in the house; this was addressed immediately. Staff told us they understood the need to ensure all personal

information was maintained confidentially.

We saw that staff respected people's privacy and were careful to maintain their dignity. We spoke with two people who had their own separate accommodation within a supported living environment. We were told, "I have my own key and staff are great because they are there when you need them but they are not in your face." Another person described staff in similar terms and said, "I've got my independence."

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 as much as possible to meet people's needs as individuals. The PIR stated, 'Staff understand that service users are our customers and consistently focus on addressing their preferences, listening and responding to needs. Care planning documentation includes person centred tools and approaches that are bespoke to the person'. We checked this out with people we spoke with who agreed that the care had been set up with their involvement and was reviewed periodically.

Both people we spoke with and their relatives commented positively about staff being responsive to care needs. Comments made included, "They always get back to you which is a positive thing," "They take [person] to places of his choice," "They are understanding and always put things into action" and "They take [person] to places and are responsive to what [person] wants to do." One person said, "I need some help with personal care. Staff have sat down and gone through this and the care plan suits me at present."

We looked at three examples of care files for people. 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 their relatives if needed. We could see from the care records that staff reviewed each person's care. We discussed how people could be encouraged to sign key assessments and care plans to evidence this further. The assessment tool for new admissions to the service had been updated since our last inspection to include a more comprehensive review of people's personal care needs.

We also saw that people's care was reviewed by social care professionals if they were funded by social services. We spoke with a social worker conducting a review of some people living in supported living and being supported by Access Community Services. The review, covering three separate supported living accommodations had been positive. We were told that staff were "Very responsive and liaised well with other supporting professionals to provided good individualised care."

A key element of the care planning was how people preferred to communicate. Some people had limited communication and understanding. The PIR stated, 'Communication passports are shared when appropriate as are hospital passports containing communication needs, staff are encouraged to record any progress or change in need and take action to ensure communication needs are fully met'. Also, the service supplied key information in an easy read format, such as the 'Service User Guide', complaints policy, compliments and concerns.

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 detailed assessment and care plan covering one person who needed increased personal care due to their health deteriorating. They had been assessed well in liaison with health care professionals and proactive 'end of life' care plan was in place to help ensure the person's care needs could be met.

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. One relative had complained previously and had received some feedback form the provider. Another relative made a complaint during the inspection. We followed this through with the manager of the community service who could give us a full background history and was able to arrange ongoing meetings with the relative concerned to discuss the issues outlined. We reviewed other past complaints which were well documented and had been investigated and responded to in line with the provider's complaints policy. There was an 'easy read' complaints policy available for people using the service or visiting the day centre.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager was supported by two deputy managers who helped run the supported living service and the domiciliary care service. There were three other office based managers such as a training manager and admin team. We could see a clear line of accountability and management structure. The PIR stated; 'Management are fully visible and available to all on a day-to-day basis'. This was supported by the feedback for the people we spoke with during the inspection. One person said, "They are always responsive to any problems, when speaking to managers and staff." A relative commented, "If I have any problems the staff would put it right."

We asked about the core principals of the organisation. The PIR stated, 'A person centred culture is embedded within the service from the top down; this ethos is consistent across our policies/procedures and communicated through our vision and values. Using PC approaches and tools helps us learn about service users in a way that keeps them in control and focuses on inclusion, equality, diversity and human rights'. We were shown a result for the most recent survey carried out by the provider asking people's views on the service; 100% of people felt they received a service developed around their wants and needs. During our inspection one relative commented, "We are very lucky; they are very approachable, reliable, and trustworthy – [person] feels really valued."

We discussed the core elements of current good practice guidance including 'Registering the Right Support'. This guidance sets out the core principals and standards applicable to services providing support for people with learning disabilities. Although meeting the key elements of the guidance, senior staff were not fully aware of the document. The registered manager advised us that all staff would be updated and this would be included in, and referenced, in future training and development of the service.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager could evidence a series of internal quality assurance processes.

We saw that survey forms were used to collect feedback from people using the service and relatives. From this the registered manager had been able to set various action plans to further develop the service. Recent developments following feedback had been the use of a Facebook page to update people about ongoing events and get further feedback. Some people had requested emails and texts and this had been actioned.

The importance of this is that it helps evidence the culture of the organisation which we found to be open and positive. Staff interviews helped to confirm this. One staff said, "It's a relaxed but supportive environment. Senior managers visit and we talk regularly. Issues are tackled and sorted."

There were regular meetings of senior care staff with the service managers. There were ten formal meetings each year and we saw notes from the most recent meetings which were well attended. Managers held regular 'Quality' meetings and agenda items included, safeguarding issues, complaints reviews, incident analysis and medication errors. Any learning form these meetings were communicated to staff. The registered manager had a clear understanding of the quality process. For example, we discussed some of

the complaints and recent safeguarding issues and how these had been managed. There was a clear pathway from receiving and assessing the issues to attending feedback from any professional input - to internal management meetings - to discussion at staff meetings and feedback if there were any lessons to be learnt. This showed clear communication and a willingness to learn from incidents. Previous regulatory failings highlighted in past inspections had now been met, which further evidenced the ability of the service to adapt and develop.

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.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. The rating from the last inspection for Access Community Services was displayed at the service and on the provider website for people to know how the service was performing.