

United Response

# Newcastle DCA

## 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 was an unannounced inspection carried out over two days on 28 January and 17 March 2016.

We last inspected Newcastle Domiciliary Care Agency (DCA) in August 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Newcastle DCA is part of the United Response group. It is registered to provide personal care to adults with learning disabilities within Newcastle, Durham, North Tyneside and South Tyneside. People are supported by staff to live individually in their own homes or in small groups, referred to as independent supported living schemes. Different levels of support are provided over the 24 hour period dependent upon people's requirements. Many of the people are tenants of their home and pay rent for their accommodation which is leased from housing associations.

A registered manager was in place. 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.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. Some people could tell us they felt safe. People appeared contented and relaxed with the staff who supported them.

Staff knew the people they were supporting well and there were enough staff on duty to provide individual care to people. Care was provided with patience and kindness and people's privacy and dignity were respected. People were supported to become more independent, whatever their level of need. Care plans detailed how people wished to be supported and people were involved in making decisions about their care. Records gave detailed instructions to staff to help people learn new skills and become more independent.

People were assisted by staff to plan their menu, shop for the ingredients and cook their own food. Other people received meals that had been cooked by staff. People were supported to be part of the local community. They were provided with a range of opportunities to follow their interests and hobbies and were encouraged to try new activities. They were supported to holiday in this country or abroad and enjoyed outings to the town, coast and countryside.

Records showed people were supported to maintain some control in their lives. They were given information in a format that helped them to understand and encourage their involvement in every day decision making. A complaints procedure was available and written in a way to help people understand if they did not read.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed. They received their medicines in a safe and timely way.

Staff said the registered manager and management team were supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

People had the opportunity to give their views about the service. There was consultation with people and family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

## 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.

People were kept safe as systems were in place to ensure their safety and well-being. Appropriate checks were carried out before staff began work with people. Staffing levels were sufficient to meet people's needs safely and flexibly. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

### Is the service effective?

Good ●

The service was effective.

Staff had a good understanding and knowledge of people's care and support needs.

People's rights were protected because there was evidence of best interest decision making when decisions were made on behalf of people. This occurred when people were unable to give their own consent to their care and treatment.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

People received appropriate health and social care as other professionals were involved to assist staff to make sure people's care and treatment needs were met.

### Is the service caring?

Good ●

The service was caring.

We observed and some people could tell us the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's

privacy and dignity.

Staff spent time interacting with people and they were encouraged and supported to be involved in daily decision making.

People were supported to maintain contact with their friends and relatives. There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

### **Is the service responsive?**

The service was responsive.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver people's care.

People were supported to live a fulfilled life, to contribute and be part of the local community. They were encouraged to take part in new activities and widen their hobbies and interests.

People told us they knew how to complain if they needed to. They had a copy of the complaints procedure and it was written in a way to help them understand if they did not read.

**Good** ●

### **Is the service well-led?**

The service was well-led.

A management team was in place who promoted the rights of people to live a fulfilled life within the community.

An ethos of individual care and involvement was encouraged amongst staff with people who used the service.

The registered manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

**Good** ●

# Newcastle DCA

## 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.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We received no information of concern from these agencies.

This inspection took place on 28 January 2016 and 17 March 2016 and was an unannounced inspection. It was carried out by an adult social care inspector. During the inspection the inspector visited the provider's head office to look at records and speak with staff and after the inspection the inspector visited three houses to speak with people who lived there and the staff who supported them.

As part of the inspection we spoke with five people who were supported by Newcastle DCA staff, five support workers, two service managers, one relative, the registered manager and operational manager. We reviewed a range of records about people's care and checked to see how the schemes were managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits that the registered manager completed.

## Is the service safe?

### Our findings

Due to some people's complex communication needs they were not able to communicate verbally with us. People appeared calm and relaxed as they were supported by staff. Other people who used the service told us they felt safe. Peoples' comments included, "I do feel safe here, the staff are kind," and, "If I was worried I'd tell the staff."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. Records showed and staff confirmed they had completed safeguarding adults training. Staff members' comments included, "I've done face to face safeguarding training with the local authority," and, "I'd tell the senior on duty if I had any concerns."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found 48 concerns had been logged appropriately since the last inspection. Safeguarding alerts had been raised by the service with the relevant local authority and investigated and resolved to ensure people were protected. The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities or independent investigations were carried out. Where incidents had been investigated and resolved internally information had been shared with other agencies for example, the local authority and the CQC.

Robust procedures were followed to safeguard against financial abuse. Many people had appointed representatives or relatives who supported them in managing or having oversight of their finances. Risk assessments were completed around finances and support plans were agreed with the person and/or their representative. Each person who had money held for safekeeping had a ledger to record their transactions. Receipts were obtained for all purchases and any expenditure over a certain amount had to be authorised. Weekly checks of the records and cash balances were carried out by management and an annual financial audit was conducted. These measures helped assure people that their money was being handled safely.

The detailed information pack people received when they started to use the service showed them in an easy read format how they would be helped to be kept safe by staff. It explained in words and pictures about protection for example, "Protecting you may mean helping you when there are people who are being nasty to you or if there are people where you live who make you feel nervous or unsafe."

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. These included environmental risks and any risks due to the health and support needs of the person such as moving and assisting, epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. Our discussions with

staff confirmed that guidance had been followed.

Positive behaviour support plans were in place for people who displayed distressed behaviour and they were regularly updated to ensure they provided accurate information. The care plans contained detailed information to show staff what might trigger the distressed behaviour and what staff could do to support the person. They provided guidance for staff to give consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed and challenging. We observed during our visit a person who was very anxious and it was thought they had toothache. The person was very well supported by staff to visit the dentist. We saw staff used positive support behavioural guidance specific to the person which advised distraction techniques and other measures to calm and help reassure the person and this resulted in a successful visit to the dentist.

A personal emergency evacuation plan (PEEP) giving guidance if the house needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed monthly to ensure they were up to date.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the service manager of the house so that appropriate action could be taken. We were told all incidents were audited in each house and at head office to check action was taken as required to help protect people. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, one service manager at a house told us a person was referred to the appropriate professionals when a certain amount of incidents were recorded.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. One staff member commented, "I am observed and checked giving out medicines regularly." Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. The registered manager told us that staff also received training with regard to administering a specialist medicine for severe seizures. This was to provide the necessary care to a person in an emergency situation until the required medical assistance arrived at the service. We were told any reported medicine errors were reviewed and action was taken to strengthen and help protect people with regard to medicines management.

Peoples' medicine support plans detailed the help they required from staff for taking their medicine. For example, for one person's support plan stated in the section, "Things I can do myself - I can take my medicine when it has been dispensed. I understand why I take my medicines and when it is due though I have prompts from support workers for this."

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required after negotiation with commissioners of the service. Staff worked in small teams with people they supported so the person became familiar with all the staff. As the service supported people to learn new skills and to become more independent in activities of daily living a person might over time

require less staff support.

People and staff had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. One of the home visits was to a new development of bungalows where people lived on their own with staff support, some over the twenty four hour period and a separate bungalow, on the same site accommodated staff members who were on call during the day and the 'sleep in' member of night staff. Staff members commented, "Support is always available for advice," and, "A senior is always on call for telephone advice."

Staff we spoke with and staff records confirmed staff had been recruited correctly. The necessary checks to ensure people's safety had been carried out before people began work in the service. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

## Is the service effective?

### Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included, "I've completed a level 3 National Vocational Qualification" (NVQ), now known as diploma in health and social care," "My training is up to date," "There's lots of training - too much," and, "We talk about training at supervision." The most recent staff survey sent out by the provider showed of the 600 staff that had responded nationally, 94% stated they agreed or strongly agreed they received "appropriate training for the job."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. A staff member commented, "I shadowed for a week." This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of work books, face to face and practical training. The registered manager told us new staff completed a twelve week induction and studied for the new Care Certificate in health and social care as part of their induction training.

The staff training records showed staff were kept up-to-date with safe working practices. The registered provider and registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as epilepsy awareness, dementia care, autism, communication, distressed behaviour, professional boundaries and equality and diversity. Managers received management training to help develop their skills managing people and other aspects of management.

Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. They said they were well supported to carry out their caring role. Staff members comments included, "I receive supervision every six to eight weeks," "I'm asked how things are going at work," and, "We talk about any service issues." Staff said they could approach the registered manager and other managers in the service at any time to discuss any issues. They also said they received an annual appraisal to review their work performance. This was important to ensure staff were supported to deliver care safely and to an appropriate standard.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. Senior staff were involved in the handover. Staff comments included, "Communication is really good," and, "We're kept up to date with people's progress."

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 people lack mental capacity

to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

CQC monitors the operation of the Mental Capacity Act 2005(MCA). This is to make sure that people are looked after in a way that does not inappropriately restrict their freedom and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. The registered manager told us an Independent Mental Capacity Advocate (IMCA) had become involved, as required by the MCA, because a person without capacity had needed some health care treatment and the IMCA had worked with the person.

The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. Within the Independent Supported Living (ISL) houses some people did require constant support to keep them safe. The registered manager was aware the deprivation of liberty process was not applicable within the supported living environment as people were tenants in their own house therefore advice was being taken from the local authority about the Court of Protection process. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity. We saw the documentation for one person where this process had taken place and the parents were court appointed deputies for their relative and a deprivation of liberty authorisation was in place to keep them safe.

People using the service were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. The registered manager told us they worked with the local authority to ensure appropriate capacity assessments were carried out where there were concerns regarding a person's ability to make a decision.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. At home visits we observed care workers always asked people's permission before carrying out any tasks. They checked the person was happy for them to proceed as they provided support to the person.

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. People required different levels of support. Some people received support from staff to help them plan their weekly menu. They would then be supported by staff to help prepare or make a meal and drinks. People commented, "I go out shopping for food," "I plan a menu with staff every week," and "I've lost weight." Some people had specialist needs regarding how they received their nutrition and staff received guidance and support to ensure these needs were met.

People who used the service were supported by staff to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from GPs, opticians, dentists, speech and language therapists, behavioural team, nurses and other personnel. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. Written guidance was available for staff with regard to people's support requirements.

## Is the service caring?

### Our findings

Not all people we visited could comment verbally about the support they received from staff. We saw they appeared comfortable and relaxed with staff. During the inspection there was a calm and pleasant atmosphere in the houses. Staff interacted well with people. Some other peoples' comments included, "I like living here, the staff are kind," "I like the people I live with," "Staff keep an eye on me," and, "Staff listen to me." A relative commented, "I think the staff are very patient and they're good."

People who used the service were supported by staff who were kind, caring and respectful. During the inspection we saw staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, a support plan for personal hygiene stated, "It is important to me to have a bath in the morning and evening. Support staff to give me lots of time to have my bath and I like to relax in the bath after washing." All people's records advised staff how to communicate with the person. For example, one person's support plan stated, "I use verbal communication and can let staff know if I like or dislike the way something is being done."

People were encouraged to make choices about their day to day lives. Their comments included, "I can get up and go to bed when I want." Not all of the people were able to express their views verbally and staff used pictures and signs to help the person to make choices and express their views. For example, peoples' individual support plans with regard to decision making included details such as, "I like information visually and explained to me in short sentences, do not overload me or give me a lot of information in advance," and, "The best time to ask me for a decision is one to one in a quiet environment with better decision making when I'm relaxed." We saw pictures were available to help the person make a choice with regard to activities, outings and food. One person's support plan for making choices stated, "Just give me a choice from two objects or pictures."

Written information was made available in other formats to promote the involvement of the person and to help them understand. For example, visually by use of pictures or symbols if people did not read or use verbal communication. We saw evidence of this with the complaints procedure, assessments and the information pack people received when they started to use the service. The information pack detailed the provider's aims of being fair to everyone so they could be supported in the way they wanted, helped to be more independent, and respecting what people wanted. They explained in words and pictures that no-one would be treated differently because of their gender, race, age, disability, sexual orientation, or religion and beliefs.

People told us they were involved and they said they were listened to. They were involved in regular individual meetings to discuss their care and support needs which also included discussion about their plans for the future and their aspirations. Some houses held monthly meetings to discuss the running of the household and asked people for any suggestions or areas for improvement.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. Support plans advised when people may want some privacy, for example, one stated, "Staff to give me space if I want, but let me know where they are so when I'm ready to talk and have company I can see staff." We saw staff knocked on a person's door and waited for permission before they went into their room. A written protocol was in place that advised male staff should not carry out personal care with females to protect the person's dignity. Support plans also included information about how people's personal care was to be delivered that respected their dignity.

The registered manager told us people who did not have relatives to provide advice and support to them would be supported by an advocate. Advocates can represent the views for people who are not able to express their wishes. An advocate would become involved where a person needed to have additional support whilst making decisions about their care. The registered manager gave an example of when independent mental health care advocates (IMHCA) had become involved when new services had been commissioned.

## Is the service responsive?

### Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. Records showed they were supported with a range of activities and these included gardening, exercise classes, theatre trips, going to discos, rambling, swimming, trips to the country and coast and meals out. People were supported by staff to go on holiday or for days out either individually or in a small group. Peoples' comments included, "I want to go to London again to see a show," "I like shopping in town," and "I'm learning to cook at college." Some people told us they were supported to attend college or day placements and evening classes if they wanted. One person said, "I cooked at college today."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. We were told a long process took place to check that people wanted to live at the house and that they were compatible with people who already lived there. The induction included visits such as tea time and overnight visits and was carried out at the pace of the person.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Support plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. Support plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. For example, one person's food and support plan stated, "I can get a bowl and cereal from the cupboard and put bread in the toaster but I need help to butter my toast," another person's for housekeeping stated, "After a bath or shower (Name) needs support to mop the bathroom floor and wipe down the bath using a cloth and the relevant cleaning product." A person told us, "Staff help me look after my money and they help me shop."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, records included, "(Name) likes to have an object in their pocket," and, "It is important for me to sit in the front of the car." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. A staff member commented, "When (Name) is upset they calm down and it helps them relax if we go for a drive in the car."

Staff at the service responded to people's changing needs and arranged care in line with people's current needs and choices. Records showed regular meetings took place with people. Weekly meetings took place to discuss each person's menu and activities for the following week and monthly meetings took place to review their care and support needs and aspirations for the following month. We saw that staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be

supported in line with their up-to-date needs and preferences.

One relative we spoke with said they were involved in discussions about their relative's care and support needs. They commented, "I'm kept informed and involved in meetings about [Name]'s care." Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Most people had visitors and some people went to spend time at home.

People had a copy of the complaints procedure which was written in a way to help them understand if they did not read. One person commented, "I'd talk to staff if I was unhappy, I think I would be listened to." A record of complaints was maintained and we saw 12 had been received and they had been investigated and resolved. Regular meetings took place with people who used the service and they were asked if they had any concerns about the support they received. Staff meeting minutes also showed the complaint's procedure was discussed with staff to remind them of their responsibilities with regard to the reporting of any complaints.

## Is the service well-led?

### Our findings

A registered manager was in place who had been registered with the Care Quality Commission since 2011.

The culture promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the houses we visited was 'open' and friendly. Staff said they felt well-supported by senior staff in the households and by staff from head office. Comments included, "I can always speak to a manager, they're very approachable," and, "I love working for the organisation." All staff members had access to a team file relevant to the household they worked in which contained the vision for the organisation and policies and procedures to protect house holders and staff.

Staff told us and meeting minutes showed staff meetings took place regularly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed service issues, health and safety, training, complaints, the needs of people who used the service and feedback from people from head office who monitored the quality of care provision. Staff told us meeting minutes were made available for staff who were unable to attend meetings. We were told staff were to be issued with United Response email accounts so managers and staff could communicate more easily and receive information swiftly. Area managers meetings took place monthly with staff who had responsibility for line managing a number of houses. Senior management meetings also took place geographically with area managers across the organisation. These meeting minutes showed identified trends were discussed from across the services and addressed at a strategic level. For example, meeting minutes from October 2015 recorded an employment and volunteering strategy was being looked at for people who used United Response services. This was to help people to be supported into employment or to be a volunteer in a work place, where appropriate.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff, family members and professionals who supported people who used the service. We saw the survey results for 2015 from relatives. They had been aggregated for the services in Newcastle. We were told all respondents received a copy of the survey results and an action plan, if required, for their information. If any trends were identified an action plan was produced which was circulated to individual houses so any required action could be taken by the service manager of the house or registered manager immediately to improve service provision.

Records showed audits were carried out regularly and updated as required. Medicines management and finances were checked on a daily, weekly and three monthly cycle. Other weekly audits included health and safety, security, fire safety and documentation. Three monthly audits were carried out and they included documentation, observation of care practice, risk awareness and staff awareness of safeguarding. The

results were reviewed by the line manager who had direct operational responsibility for the service. The service manager told us the peer audit was carried out by another service manager to provide an independent view of the service. Their three monthly visit was to speak to people and the staff regarding the standards in the service. They also audited a sample of records, including care plans and staff files. A six monthly area manager audit also took place to review the quality of care provided. These audits were carried out to ensure the care and safety of people who used the service and to check that appropriate action was taken as required.

We saw the results for the questionnaires sent out to relatives and people who used the service in the Newcastle area. Results were mostly positive but where improvements were identified for example, to involve relatives more in the reviews of people who used the service, we saw the action that was taken to make improvements. A staff training module was being developed with some relative involvement with regard to working with families and this training would be provided to all staff from April 2016. The registered manager had sent out the findings of the survey to families and people who used the service to inform them of the results and how improvements would be made.

The provider survey results for 2015 also showed the organisation was taking action to improve individual communication with people and families and a relative communication plan was being developed with each person and their family to assist with communication. A three monthly forum was already held at head office that relatives attended to be kept up to date with the running of the organisation.