Natural Ability

Natural Ability

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18 and 19 August 2016 and was announced. We last inspected this service in February 2015 and found no breaches of regulations at that time.

Natural Ability is registered with the Care Quality Commission as a supported living service which provides care and support to people in their own homes who have a learning disability or autistic spectrum disorder. A registered manager was in post who was also the registered provider of the service.

At the time of our last inspection there was only one person in receipt of personal care and support from the service on a supported living basis (living in their own home and in the community), and this number had increased to a total of six people at this visit. There were a further two young adults/children with disabilities receiving personal care in the pursuit of activities in the community, on a respite/outreach basis. The day farming service was attended regularly by groups of between one and six adults on weekdays.

People told us they felt safe when they received care from the service. Most staff had received training in the safeguarding of vulnerable people and they were aware of their individual responsibility to report matters of a safeguarding nature. Records showed there had not been any safeguarding incidents since our last inspection and the local authority safeguarding team confirmed that there were no on-going safeguarding cases.

Risks that people had been exposed to in their daily lives and within the environment of their own homes had been assessed and mitigated against. Regular health and safety checks were carried out. Accidents and incidents were monitored, analysed and measures were put in place where necessary to prevent repeat events.

Staffing levels within the service were tailored to the needs of the people in receipt of care, and as much as possible, staff worked in teams around the care of each individual. Staff files demonstrated that the provider's recruitment and vetting procedures of new staff were appropriate and protected the safety of people in receipt of care from the service. Medicines were managed safely and appropriately. Most staff were trained in key areas relevant to their role, such as manual handling and emergency first aid, and also in areas such as epilepsy awareness which was relevant to the needs of some of the people they supported. One staff member's training had been overlooked and we have made a recommendation that the provider "Reviews all staff member's training to ensure they are all fully equipped with the skills they need in respect of the role they carry out within the service". There was an induction package in place and supervisions and appraisals took place but had fallen behind in recent months.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act 2005 (MCA) was appropriately applied and the service understood their legal responsibility under this Act. Documentation around capacity assessments and decisions that were made in people's best interests in line with procedures set out in the MCA, were not well maintained. People's

capacity was informally assessed by the service when their care commenced and on an on-going basis when necessary. The provider told us that records in this area would be improved in future.

People were supported to eat and drink in a way that allowed them to remain healthy. Monitoring tools were used to ensure that any changes in people's health and wellbeing could be identified and actions taken where necessary to identify any changes in people's conditions. For example, food and fluid charts were used to promote healthy eating and people were weighed regularly. People were also supported where necessary to access healthcare appointments in order to maintain their overall health and wellbeing.

Staff and people enjoyed good relationships and we observed friendly, caring and respectful engagements between both parties when we visited two people in their own home. People described how staff supported them to do what they wanted and to become as independent as possible. They told us they were pleased with the service they received. Relatives described how they had noted positive and visible changes in their family member's abilities, their independence levels and their overall presentation since they started using the service. People accessed the community and pursued activities of their choosing with staff support and goals and targets to becoming more independent were set for them to work towards, such as working towards being able to travel independently and safely. Staff were responsive to people's needs; they provided person-centred care and supported people to make their own choices in all aspects of their daily lives.

Personalised care records were in place for each individual in receipt of care which identified their abilities and areas of daily living in which they required support from staff. Care and support plan, and risk assessment documentation was kept under review throughout the year. Staff told us they felt they had enough information about each person they supported and consequently that they were able to care for them in both a safe and appropriate manner. We found that further information and detail was needed in some care records. We have made a recommendation that the provider, "Reviews all people's care records to ensure they are an accurate, complete and contemporaneous record in respect of each service user and that care delivered and decisions made are appropriately recorded".

People, their relatives and staff spoke highly of the service and management team. The organisation had clear vision and values to enrich people's lives, and to promote independence and community involvement as much as possible. This echoed the provider's statement of purpose. The registration requirements of the service had been met and there was no evidence that any incidents or changes had occurred within the service which needed to be reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

We identified some minor concerns with the governance and management oversight of the service which we fed back to the registered provider. These related primarily to the maintenance of records, where the provider had not identified these through their own quality monitoring and assurance systems. There was a lack of oversight of staff training as a whole and no system was in place for monitoring that supervisions and appraisals were carried out. These had fallen behind. There was also no formal observation of staff practice when they delivered care, or their competencies related to the administration of medicines.

We have set a recommendation about this which states, "We recommend the provider reviews their governance and quality assurance systems within the service, to ensure that shortfalls such as those highlighted above, are identified and then addressed promptly".

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 said they felt safe and comfortable when receiving support from staff.

Staff understood their personal responsibilities to safeguard vulnerable people.

Staffing levels were determined by people's needs and people were supported to take their medicines safely.

Risks that people faced in their daily lives and within their home environments were assessed and mitigated against.

Is the service effective?

Good

The service was not always effective.

People and their relatives were satisfied that they received a good service.

People's nutritional needs were met and well managed. Staff supported people to access healthcare services as and when required.

Induction, training, supervision and appraisal were carried out, but some supervisions had fallen behind. One staff member's training needed to be reviewed.

The Mental Capacity Act was appropriately applied but detailed records about capacity assessments and best interest decision making were not maintained.

Is the service caring?

Good

The service was caring.

People told us staff were helpful and kind.

They said they were treated with dignity and respect and we saw that their independence was promoted.

People and their relatives were involved in the service and kept informed about changes to people's care.

No formal advocacy services were currently used to support people in receipt of care.

Is the service responsive?

Good

The service was responsive.

People were supported in a way that was responsive to their needs.

People had choices and pursued a range of activities in their daily lives.

Care was person-centred and overall care records were well maintained.

Feedback was obtained at meetings and via a direct approach to management.

No formal complaints had been received within the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

Minor concerns related to governance and management oversight of the service were identified.

Some auditing took place but this was not extensive. Some records lacked detail and could be improved.

The organisation had clear visions and values which they strove to achieve.

The registration requirements of the service were met.

Natural Ability

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 18 and 19 August 2016 and was announced. We gave the provider 48 hours short notice of our inspection visit because the location provides a domiciliary care service for younger adults who are often out during the day and we needed to be sure that someone would be in to assist us. The inspection was carried out by one inspector.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This 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 reviewed the PIR and also information that we held internally about the service. We also sought feedback via questionnaires in advance of the inspection from people who used the service, staff, relatives and community healthcare professionals, and we used their feedback to inform our judgements. We contacted Northumberland Safeguarding Adults team, Northumberland Contracts and Commissioning team and Northumberland Healthwatch in advance of our inspection to ascertain their views of the service. We used the information they provided us with to form the planning of our inspection and judgements.

During our inspection we visited two people in their own homes to talk with them about their experiences of using the service. Following our visit to the service we contacted two people's relatives and two healthcare professionals who provided feedback about the service. We also spoke with nine staff in total, including the provider, services manager, manager of the independent living element of the service, the business development manager and members of the support staff team. We viewed three people's care records, five staff files including information on training, supervision and recruitment, and records related to quality assurance and other management aspects of the business.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving care and support from staff. Comments they made included, "I feel safe" and "I am comfortable with staff". Both of the people we spoke with confirmed they were treated well by staff and they had never felt at risk when in their care. One relative told us, "I feel (name of person) is safe". We observed one member of staff whilst they were supporting these people in their own home and we had no concerns about the way they interacted and engaged with them.

People in receipt of support from the service had a variety of differing needs. The people we observed were working towards increasing their independence, but needed support with everyday activities such as shopping, cleanliness, cooking and travelling.

Training records showed that staff had undertaken training in safeguarding adults and staff told us how they would handle any matters of a safeguarding nature in line with company policies and procedures. Staff were aware of their own personal responsibility to report matters of a safeguarding nature, should they occur. The provider's safeguarding and whistleblowing policies gave detailed guidance to staff on how to report safeguarding matters and a list of contact details for the relevant parties to whom they should relay information. The services manager told us that there had not been any safeguarding incidents since our last inspection and this was confirmed via records held within the service and our discussions with staff.

Staffing levels within the service were tailored to the needs of the people in receipt of care and as much as possible staff worked in teams around the care of each individual, or number of individuals in a home. Some people were supported on a one to one, or two to one basis, either over a 24 period or just at specific times of the day. Other people, who lived in shared houses, received support on a one to two basis where only one staff member was needed to support two people. Staff told us staffing levels were fine and they were able to support people in the way they both wanted and needed support. During our visit to one shared home we saw that the staffing ratio of one staff member to two people was suitable for the people's needs. The provider told us that any shortfalls in staffing were covered by staff within each individual staff team, or if that was not possible, some staff worked across a number of different care packages within the service and could be deployed to work wherever needed.

Staff files demonstrated that the provider's recruitment and vetting procedures of new staff were appropriate and protected the safety of people in receipt of care from the service. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. An induction and on-going training plan was in place for staff to complete once they were employed. This meant the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit and appropriately qualified to do their jobs.

People were supported to take their medicines by staff. Some records around the level of support people

needed to take their medicines safely were not as detailed as they could have been and they did not specifically state the abilities of the person and the role of staff. We did not see any impact on people because of this. We discussed this with the provider and services manager who told us care records related to medicines support would be reviewed and improved as soon as possible. Medicines were stored in their original containers or monitored dosage systems within people's own homes. Staff told us they supported people to obtain their medicines via prescription from the doctor's surgery when needed. People told us they received the medicines they needed. One person told us, "They always help me do my medicines". A medication policy was in place and audits of Medication Administration Records (MARs) were completed monthly to ensure the recording of the administration of medicines was correct and there were no concerns about how staff supported people in this area.

Accidents and incidents that had occurred within the service were few and far between. Where they had occurred records showed they were appropriately managed to ensure that people remained safe. Preventative measures that could be introduced were, and medical attention was sought where needed.

Risks which people were exposed to in their daily lives had been assessed and written instructions were in place for staff to follow in people's care records about how to manage and reduce these risks. These included, for example, the assessment of risks associated with people accessing the community, such as crossing roads, going swimming and losing personal possessions or money. There were other general risk assessments in place for activities of daily living such as using sharp cutlery, cooking and scalding. Risk assessments were reviewed on average every six months and updated where necessary.

Staff supported people on a daily basis to assess environmental risks within their own homes and seek professional input from for example, plumbers or joiners if needed. Regular formalised health and safety checks in people's homes were carried out by the independent supported living services manager on a monthly basis and documented. Where any matters needed to be addressed the independent supported living services manager allocated tasks out to staff and a date was set by which these tasks had to be completed. This showed the provider sought to ensure the health and safety of people, staff and visitors.

A file which contained emergency contact information was in place in each person's home and was easily accessible. This included the contact details for all management within the service and an 'on-call' rota was in use to support staff should assistance be needed during the course of their shifts. There were also contact details for losses of utilities, such as electricity, and any other emergencies.

Good

Is the service effective?

Our findings

People described how staff supported them to do what they wanted and to become as independent as possible. They told us they were pleased with the service they received and this was echoed in the feedback we received from their relatives. One person said, "They (staff) are really good" and another told us, "We do travel training". The person explained that 'travel training' was about supporting them to use buses and trains, and to walk around the local community as independently, confidently and safely as possible.

Relatives described the impact they felt the service had had on their family member in terms of their wellbeing and independence. One relative said, "I can't praise the service enough. They put in a huge amount of effort into finding the right staff to support (name of person); they are well-trained and the communication with us is excellent. What we really appreciate is getting (name of person) to be more independent and do things for themselves. They do this carefully and are continually making little steps forward. (Name of person) is doing things that we thought they wouldn't and they are branching out and becoming more confident. Other members of the family are commenting on how happy (name of person) is and how well they are doing". A healthcare professional told us, "I have no complaints about this service. It has made a big difference to my client". This demonstrated that the care people received was effective because it had made positive changes to people's lives.

We observed care being delivered to two people in their home and saw their needs were met. Staff were clear about people's needs and how to support them appropriately. For example, when we asked staff about particular people's needs and behaviours they were able to explain these in detail to us and they clarified how they would support people to manage their needs. The information they gave us tallied with information held in these people's care records and our own observations.

People's nutritional needs were met and managed well. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy. People were weighed monthly to ensure that any significant fluctuations in their weight were identified and could be investigated. One person had received input into their care from a dietician and information about how to support them in respect of the advice given had been retained in their care records within their own home. Staff were knowledgeable about how to provide the appropriate support to each person.

When we visited the home of two people we saw they had access to stocks of foods to support a healthy diet, and on a board in the kitchen, meals for the forthcoming week were listed. People told us they decided on the meals that they would eat in the week ahead with support from staff, who took them food shopping. There was sufficient access to food and drink to maintain the people's well-being.

People were supported to maintain their general health and wellbeing. One person told us, "They (staff) help us to make appointments for the doctors if we need them". Staff told us they did not hesitate to refer any matters related to people's health to healthcare professionals and their managers. They said they supported people in any way they could by making appointments for them and supporting them to attend these appointments if necessary.

Staff files contained information about induction, training, supervision and appraisal. A service specific induction about company policies, procedures and code of conduct was in place and the Care Certificate induction standards had been incorporated into the induction package. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and brought into force in April 2015. It is a set of minimum standards that social care and health workers follow in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers.

Records showed that staff were trained and equipped with the necessary skills to support people who used the service. For example, staff had undertaken training in areas including safeguarding, medication, person centred care, epilepsy awareness and understanding behaviours which challenge. One staff member had only received informal training in safeguarding and the safe handling of medicines. Although we observed no concerns with their practice we considered that they should have been supported to access training from an accredited training provider. We discussed this shortfall in the person's training with the independent supported living manager and the provider. They told us that this oversight would be addressed and the staff member would be trained as soon as practicable.

We recommend the provider reviews all staff member's training to ensure they are all fully equipped with the skills they need in respect of the role they carry out within the service.

In three of the five staff files we looked at supervisions had not been carried out for several months. The independent supported living manager told us that these had fallen behind due to work pressures, but they would endeavour to get these completed as soon as possible. Most staff who worked for the service had not been employed for over 12 months, so an annual appraisal of their performance had not yet been carried out. There was however a form in place for future use and historic appraisals for more longer-standing members of staff were available for us to view. Supervisions and appraisals are important as they are a two-way feedback tool through which the manager and individual staff can discuss work related issues, training needs and personal matters if necessary.

Staff told us that communication within the service was good and they were kept fully informed about any matters affecting their role or the people they supported. Some staff said at times they felt important messages were not relayed as effectively as they could have been. People and their relatives told us they felt that staff and management communicated with them regularly and at an appropriate level. Healthcare professionals who had previously worked with the service told us that communication had been mixed and at times it could have been better.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for these authorisations in a community setting are made through the Court of Protection. The provider and services manager told us that to their knowledge no people currently using the service had a deprivation of liberty order in place and no supported individuals displayed personal care needs that would warrant a deprivation of liberty order to be sought from the Court of Protection. They described how best interest decisions were made within the service and informed us that people's families and care managers (social workers) were consulted in the

process.

We noted that detailed records about best interest decisions that had been made were not retained within the service, for example, around the management of people's finances. The provider and services manager told us that for some issues capacity assessments had been carried out by people's care managers and these assessments were retained by them within their own organisations. They told us that in respect of any future best interest decision making, they would ensure that accurate and detailed records were drafted and maintained within people's care records, including capacity assessments, in order to better evidence the process and who was involved.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring, friendly and looked after them well. One person told us, "The staff are good; they are helpful". We observed staff displayed caring and compassionate attitudes towards people. They enjoyed good relationships and the people we observed appeared comfortable in the presence of staff enjoying pleasant and jovial interactions. They confirmed that they did, when we asked them if they felt safe with the staff who supported them.

People told us they were involved in the service. One person said, "We get involved in everything". We visited two people in their home when it was close to a mealtime and observed the staff member on duty actively involved and encouraged one of the people to look up a recipe and work out how the meal needed to be prepared.
People told us that they could look at their care plans whenever they wanted to and these were accessible to them within their own home. They said they were kept informed about any changes to their care and we saw that people and their relatives were regularly involved in meetings held within the service and also care review meetings held with care managers in the local authority. Both of the people we visited told us they saw their relatives regularly and this was actively encouraged by staff and management.

Records within people's home were stored securely in a separate room to prevent unauthorised access. This protected people's dignity and confidentiality. We saw people were treated with dignity and respect and staff had received training in this area. The staff member we observed was kind and considerate in their engagements with people and asked them what they wanted to do before undertaking any tasks or activities. They respected the responses people gave and the choices they made.

The ethos of the service was very much about promoting the independence of each and every person in receipt of care so they could live a fulfilled and enriched life. People were encouraged to do as much as possible for themselves. The observations we made, and the care records and risk assessments we viewed, reflected this. People described how they accessed the community with staff support but they were encouraged to develop their independence through goals and plans that had been established with their involvement at keyworker meetings. We saw people were encouraged to get their own drinks and cook their own food, and they told us they were supported to do their food shopping and to develop their skills when using public transport. This showed the provider actively encouraged people to be as independent and responsible as possible.

People's relatives' spoke highly of the service's drive to fulfil people's potential to become as independent as possible. One relative said, "We are absolutely delighted with the service. They are very, very keen in supporting (name of person) to be as independent as possible. (Name of person) is more confident and happy. It has been a real positive for us".

Our discussions with staff revealed there were no people in receipt of care from the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no

evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The provider and services manager told us that no people currently using the service accessed the services of a formal advocate but that this could be arranged through their care managers if needed. They informed us that people's relatives usually advocated on their behalf where necessary and that staff and management also did this on occasions.

Good

Is the service responsive?

Our findings

People told us that staff were responsive to their needs and supported them to make choices. One person said, "If we change our minds, staff will do whatever we want". They told us about the activities they pursued in their daily lives and said that they were supported to access healthcare services whenever this was needed.

Personalised care records were in place for each individual in receipt of care which identified their abilities and areas of daily living in which they required support from staff. The services manager told us that assessments of people and their needs and dependencies were carried out before they started using the service and this information was captured and incorporated into a care and support plan. We saw people's care and support plans documented their abilities and needs in areas such as, physical care needs, medical and dietary care needs, communication, social and emotional needs and financial support. Some people had morning and evening routines documented depending on their needs and, where necessary, personal behavioural care plans were in place detailing proactive, reactive and preventative strategies for staff to employ. There was a 'pen portrait' of the person and a section where short and long term goals had been discussed with the person and then set. Risks that people were exposed to in their daily lives had been documented including for example, risk assessments related to accessing the community, going on holiday, dealing with finances and hazards around the home.

Care and support plan and risk assessment documentation was kept under review throughout the year and there was evidence that 'Review meetings' about people's care were undertaken with people, their relatives, staff and care managers from the local authority. This showed the service ensured people's care and support needs and risks that they were exposed to in their daily lives were assessed, reviewed and they remained current and up to date. Staff told us they felt they had enough information about each person they supported and consequently, that they were able to care for them in both a safe and appropriate manner. However, despite this feedback from staff, we found that further information and detail was needed in some care records. For example, around people's abilities to take their own medicines and the exact role of staff in this area to ensure people received the medicines they needed at the right time. In addition, care records were not written in a format that people using the service could read and understand themselves without staff support, for example, in pictorial format. We discussed this with the provider who told us that care records would be reviewed and improved.

We recommend the provider reviews all people's care records to ensure they are an accurate, complete and contemporaneous record in respect of each service user and that care delivered and decisions made are appropriately recorded.

Care monitoring tools were in place, including detailed daily notes which gave a thorough description of any matters, incidents and activities people had pursed each day. Where necessary food diaries and fluid monitoring was undertaken and people were weighed monthly, in line with their nutritional needs. Activities charts were also retained within people's houses to show what leisure activities they had pursued and a 'Participation chart' was used to demonstrate people's level of involvement in activities of daily living, to

help monitor and track their development towards achieving greater independence. Staff told us they had a verbal handover when each staff shift changed over and also that a communication book was used to pass key messages between staff and also management and staff, which they had to sign to evidence they had read.

People's care was person-centred. They experienced positive outcomes and their care needs were met. Records showed staff were responsive to people's needs and promoted their health and wellbeing.

Social inclusion was promoted both within people's homes, where we observed people pursuing recreational activities together and with staff, and also within the local community. People were encouraged to undertake activities of their choosing and they told us they enjoyed pastimes such as shopping and swimming. One person told us they worked in a charity shop one morning a week and they enjoyed this work. Another person told us they were due to start college in September which they were looking forward to and that in addition to college they were planning to undertake some work in a local cafe. During our visit to the home of two people we heard the staff member say to them, "What's the plan for the weekend then, what would you both like to do?" This showed that people had choices about how they spent their spare time and the activities they pursued. They told the staff member they wanted to go shopping to a local home furnishing store and without hesitation the member of staff said this would be arranged. People told us they were always able to make choices in their lives and we concluded they had as much control and independence as possible.

The services manager and provider told us that no formal feedback systems had been developed within the service to proactively gather the views of people and their relatives. They said that the service had expanded from supporting one person to now supporting six people with personal care, and an annual survey or the distribution of questionnaires was something that they planned to introduce. People and their relatives told us they could approach staff or management at any time with any feedback they may have. Staff told us they had the opportunity to give feedback to management during their supervision sessions or at meetings, but that no annual staff surveys were carried out.

No formal complaints had been raised within the service. One person told us, "If I was not happy with something I would tell staff who are on duty. They would help me". A relative said, "Any little issues get discussed straight away so they don't escalate to a complaint". The provider had a detailed complaints procedure in place which gave guidance to people and their relatives about how to complain, the timescales involved and how matters could be escalated should the complainant remained unsatisfied with the company's investigations and response.

Requires Improvement

Is the service well-led?

Our findings

The independent supported living manager told us they carried out monthly inspections of the service people received and visited them in their own homes to ascertain if they were happy or there were any issues or concerns. Staff and people confirmed that these monthly visits occurred. One person told us, "(Name of independent supported living manager) comes and sees staff and us and asks how we are doing". We saw that as part of these visits, checks on Medication Administration Records (MARs) and medicines stocks were carried out, in addition to finance files, care related documentation, environmental issues and any other miscellaneous matters. Fire alarm testing was also carried out monthly. We saw that actions from these monthly audits were noted on the summary of check results and these were allocated to individual staff members to complete with a date for completion also noted. This meant that there was accountability for staff to drive through improvements.

We identified some minor concerns with the governance and management oversight of the service which we fed back to the registered provider. These related primarily to the maintenance of records, where the provider had not identified these shortfalls themselves through their own quality monitoring and assurance systems. For example, best interest decision making was not appropriately documented and some people's care records lacked specific detail around the management of medicines, which meant there was a risk that people may not receive the correct levels of support related to their abilities and needs. Paperwork related to monthly visits to people's homes lacked detail around the nature and number of individual checks completed. The services manager took on board our feedback and said that this would be reviewed.

In addition to the shortfalls we identified with records within the service, we found that there was a lack of oversight of staff training as a whole, although plans were in place to develop a training matrix. This could be used to highlight when members of staff need their training to be delivered or refreshed. Records showed and the independent supported living manager confirmed, that some staff member's supervisions had fallen behind. There was no system in place for monitoring that supervisions and appraisals were carried out. There was also no formal observation of staff practice when they delivered care and their competencies related to the administration of medicines.

Meetings took place related to each person and their care, and also staff meetings, but staff told us these were sometimes sporadic. One person's records showed that they had not had a meeting with their keyworker to discuss their care, and set goals and targets for them to achieve, since February 2016. Staff confirmed they had not carried out a key worker meeting since this date and could provide no explanation as to why not. A relative also told us that 'keyworker meetings' for their family member seemed to have "fallen by the wayside a bit" recently and they would appreciate these being reintroduced. Although the independent supported living manager visited people's homes monthly to audit records (amongst other things), the lack of keyworker meetings being carried out by staff monthly had not been addressed. There was also a lack of formal feedback systems in place to measure the service delivered and to drive improvements within the service.

We recommend the provider reviews their governance and quality assurance systems within the service, to

ensure that shortfalls such as those highlighted above, are identified and then addressed promptly.

At the time of our inspection a registered manager was in post, who was also the registered provider of the service. They had been registered with the Commission to manage the carrying on of the regulated activity 'Personal Care' since December 2014. The registration requirements of the service had been met and there was no evidence that any incidents or changes had occurred within the service which needed to be reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

The organisation was a registered charity with a board, registered provider, business development manager, services manager, independent supported living manager, personal development worker and administrative staff. People, their relatives and staff told us they thought the service was well led and said that management in general, including the registered provider/manager, were approachable. One staff comment we noted from a questionnaire that was returned to us in advance of the inspection read, "Natural Ability are the most professional and caring company I have experienced, both in terms of how they treat their staff, and also how they provide care for service users". Another returned staff questionnaire read, "I have always felt very supported, valued and listened to as a member of staff within Natural Ability. I feel that there is always someone at the end of a phone to give me advice or to pass on any concerns to". Staff told us that morale amongst the staff team was generally good and one member of staff commented, "I feel supported. If you are feeling stressed or anything you just ring up and say that". Another member of staff told us that the support they received could be better.

Healthcare professionals linked to the service commented that they enjoyed a good working relationship with the provider and other members of staff who they had contact with. One returned questionnaire completed by a community healthcare professional read, "From the limited dealings I have had so far with this provider, they seem competent and capable. They are just starting out in terms of running/staffing an ISL but have so far proved to be a good choice and are supporting my client well. I have noticed a very positive change in my client since Natural Ability took over the service".

We spent time with the registered provider/manager talking about her vision for the service. She told us, "It is about providing what people want and need, and what they are asking for. It is working with people for a personalised aspect to our care. We want people to fulfil their potential and enjoy the same things in life that other people can. I want them to feel part of and valued by the community".

The organisation's 'vision' in their statement of purpose was person centred and placed people at the heart of the service. It read, "Natural Ability's Community Living Programme (supported living service) aims to support individuals with learning disabilities to live in a rural community, contributing to and being fully integrated into that community, learning and developing independence and daily living skills and achieving their potential". The feedback we received at this inspection, and our own observations, confirmed people received care which met the provider's vision. There was a positive culture within the service which promoted openness and an application of human rights, diversity and equality during care delivery. Staff and people told us if they raised any minor issues of concern the provider acted upon these.

The provider promoted community links and offered services to other members of the public with learning disabilities and autism spectrum disorder, which were not regulated by the Commission. For example, the service operated a 'Day Farming' service from Monday to Friday where people could pursue a range of horticultural, animal care and conservation activities. Some people accessed this service daily, others on a number of set days a week, depending on their interests. The service had a minibus which it used to transport people who accessed the 'Day Farming' element of service provision. Natural Ability also offered educational packages with teaching staff, to younger adults and children with learning disabilities and

autism. Educational packages were delivered on a full time or part time basis depending on whether or not the person was still attending school. All of these services could also be used by people in receipt of personal care and support from Natural Ability.