Aspirations Care Limited

Aspirations Southwest Adults

Inspection report

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Date of inspection visit:
22 March 2016
23 March 2016
24 March 2016
29 March 2016

Date of publication:
27 April 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22, 23, 24 and 29 March 2016 and was announced. Aspirations Southwest Adults provides personal care to people with a learning disability, sensory or physical disabilities and people living with mental health conditions in their own homes in Gloucestershire. Aspirations Southwest Adults was providing personal care to 28 people living in 13 houses at the time of our inspection.

There had not been a registered manager in post since February 2016. 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 and associated Regulations about how the service is run. A manager had been appointed and had started the process to apply to the Care Quality Commission to be considered as a Registered Manager.

Aspirations Southwest Adults had been through considerable changes in the past three months including a new manager and a new management structure which had increased the level of management support to people using services. In addition a review of staff supporting people in their homes had allocated staff teams to work in specific services rather than across multiple services. Additional staff resources had also been allocated such as the support of the quality assurance manager and a training mentor to work alongside the new managers. Service managers had started to set up individual meetings with their staff teams to offer them one to one support and to implement the use of new records detailing people's daily lives and any accident and incidents. These changes were starting to have positive effects for both people using the service and staff but as staff commented, "It's too early to say, we can see from what they say we are moving forward, this can only be good."

People's experience of the service they received was varied. There were still some inconsistencies in their access to activities in their home and their local community. Some people lived full and busy lives whilst others spent considerable amounts of time in their homes. For some this was a lifestyle choice but for others this was said to be due to the availability of staff. Plans had been developed with people to try new activities or to be more engaged in their homes and for some this had already shown signs of success. People kept in touch with their families and friends.

People's rights were upheld and they were supported by staff who had a good understanding of how to keep them safe. People were encouraged to take risks whilst any hazards were reduced as far as possible. They made choices and decisions about their day to day care and support and if they needed help to make larger decisions this was provided in the form of best interests meetings. People's medicines and finances were monitored closely to make sure they were managed safely.

People benefitted from staff who had access to training to equip them with the skills and knowledge to meet people's needs. Staff completed an induction which included a nationally recognised care certificate and had the opportunity to develop professionally. Staff said "communication had improved" and were positive

about the changes to the management structure which made service managers more accessible to them. People had been involved in the recruitment of staff and had been asked about the qualities they would like their staff to have. They listed being "fun" and "listening to them". Staff teams had been allocated to people in their homes providing consistency and continuity of care, which relatives confirmed was so important.

People had been asked about their views of their care. They were asked to respond to an annual survey, invited to bi-monthly coffee mornings and reviewed their care with staff each month. The provider had a range of quality assurance audits in place monitoring the service provided and taking action when needed to make the necessary improvements.

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's rights were upheld. Risks had been assessed and minimised to prevent injury or harm.

Recruitment and selection processes were robust ensuring staff of the right character had been appointed. There were enough staff to meet people's needs flexibly and to ensure their safety.

Medicines were administered and managed safely.

Is the service effective?

Requires Improvement

The service was not always effective. Changes to the way in which staff were supported and supervised through individual meetings had not yet been embedded. Better communication and greater consistency were starting to improve people's experience of the care and support provided.

Staff had the opportunity to acquire the skills and knowledge relevant to people's individual needs.

People were supported to make choices and decisions about their care and support which reflected the requirements of the Mental Capacity Act 2005.

People were supported to stay well and healthy. Their individual dietary needs were taken into account. They had access to a range of health care professionals to maintain their physical health and mental well-being.

Is the service caring?

Good

The service was caring. People had positive relationships with staff who they liked to be "fun" and to "listen to me". People were treated with dignity, respect and sensitivity and their human rights and diversity were upheld.

People's views about their care were encouraged and they were actively involved in making choices about their care and support.

People's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's experience of social activities and following their interests was varied; although there were plans to improve people's lifestyles and the opportunities offered to them.

People's care was personalised and reflected their individual preferences, likes and dislikes and routines important to them. Their care records were reviewed with them and kept up to date.

There were arrangements to respond to any concerns and complaints by people using the service or their representatives.

Is the service well-led?

Requires Improvement

The service was mostly well-led. Changes made to improve people's experience of their care and support had either not been fully implemented or were not yet embedded into practice.

People's views and those of the staff, had been sought and action was taken to address and respond to their opinions.

The manager was making considerable changes to the way in which the service was delivered. People and staff were positive about these changes and the impact they were starting to have on the quality of service provided.

Aspirations Southwest Adults

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.

The inspection took place on 22, 23, 24 and 29 March 2016 and was announced. Notice of the inspection was given because we needed to be sure that the manager would be in. Two inspectors and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was people with disabilities and mental health conditions. Before 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 also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with twelve people using the service and four relatives. We spoke with the manager, two representatives of the provider, five service managers and eleven care staff. We reviewed the care records for six people including their health care records. We also looked at the recruitment records for five staff, staff training records, complaints, accidents and incident records and quality assurance systems. We observed the care and support being provided to six people. We contacted 10 health and social care professionals and asked them for their feedback about this service.

Good

Is the service safe?

Our findings

People's rights were upheld. When people experienced abuse or harm the appropriate steps had been taken to keep them safe and to prevent further abuse or harm reoccurring. Staff had a clear understanding of safeguarding procedures and said they would raise concerns if they suspected people had been harmed in any way. Staff commented, "Safeguarding is paramount for me." They described what actions they would take to keep people safe, to maintain clear and robust records and to contact senior managers who would then raise safeguarding alerts with the appropriate authorities. The manager shared with us the detailed records of investigations into safeguarding incidents and the action taken in response to these. For example, the theft of people's money or the conduct of staff. Staff had been supported to reflect on their practice and support or additional training were provided if this was the appropriate response. When necessary disciplinary procedures had been followed and there was evidence staff had been dismissed if needed. The manager had involved safeguarding authorities and the police if warranted. They had also notified the Care Quality Commission (CQC). The provider had kept CQC informed about the progress of any police or internal investigations.

People told us they felt safe, "Yes I feel very safe with the staff and in the house" but they found "Strangers [new staff] come into my home I find it off putting and unsafe". In response to the last comment changes to the team structures had meant greater consistency of staff supporting people. People had access to a dedicated telephone line which they could call anonymously if they wished to raise concerns. Staff could also use this system to raise any concerns they might have. Staff said they would use the organisation's whistle blowing procedure; "I have no problem whistleblowing" and "I would whistle blow but I have no reason to." Staff were confident the manager would listen to them and take the necessary action in response. Staff had access to safeguarding training and also discussed safeguarding as part of their staff meetings.

People's personal finances and possessions were managed as safely as possible. In response to thefts of money from people's homes the provider had reviewed their financial procedures. Each person had a financial assessment detailing their personal income and expenditure and how they were supported to manage their finances. When people needed help from staff to withdraw money from their bank access to their cash cards was restricted to the service manager and a named member of staff. Financial records were kept for all transactions and receipts were cross referenced with entries. People signed these records which were also countersigned by two staff as correct. They were also audited as part of the provider's quality assurance process. Discussions with the manager had focussed on how these financial records could be made more robust. As a result recent audits confirmed a significant improvement in the accuracy of record keeping. People also had an inventory for their personal possessions which kept a record of items valuable to them. Some people had also been supplied with secure facilities in their rooms in which to keep personal possessions.

Any hazards people faced had been risk assessed and records identified how these had been reduced to prevent harm or injury. Risks were identified as high, medium or low and for most people the strategies to minimise these had reduced the level of risk. Occasionally, despite controls being put in place some risks

continued to be high. Staff were prompted to be aware of these and promoted to take positive risk taking to enable people to live life as independently and fully as possible. Sometimes this resulted in restrictions having to be put in place to keep people safe such as locking the kitchen when staff were not around.

People had individual evacuation plans in place should they need to leave their homes in an emergency. These were reviewed and kept up to date with any changes in their needs for example declining mobility. There had been problems with the out of hour's system used by staff in an emergency with staff not being able to access the advice or support they needed. The manager had reviewed this and service managers told us the new system had worked much better. One service manager took the lead for out of hour's calls and another service manager provided back up. A service manager told us there had been a reduction in the use of this service which they thought was due to its effectiveness and increasing staff confidence.

When people had accidents or incidents these were recorded in their daily notes. The representative of the provider acknowledged there had been an under reporting of incidents by staff. As a result, staff were to be offered additional training in the completion of accident and incident records and given guidance about what they should be reporting. Service managers had already received this training and were supporting staff to make sure thorough records of any incidents were kept. New daily records included a blank body map on which to record injuries or unexplained bruising and prompted staff to complete an accident and incident form. These records were monitored and analysed by the provider to assess if the appropriate action had been taken, that risks had been reduced or were ongoing and whether additional resources were needed.

People were protected through satisfactory recruitment and selection procedures which made sure new staff were only appointed after all the relevant checks and records had been obtained. A checklist evidenced when information had been requested and returned such as references to verify the character and skills of applicants and disclosure and barring service checks. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. A full employment history had been requested and gaps explored if needed. Evidence of identity had been obtained including a current photograph. People helped out with the recruitment process either formally as part of the interview process or informally meeting and greeting applicants.

People were supported by enough staff, with the right skills and knowledge to meet their needs. Staff said a recent management restructure and review of how services had been allocated to staff had resulted in a significant improvement for both people using the service and staff. There was now greater consistency and continuity resulting in the same staff working with people. People had been allocated different levels of staff support by the commissioners of their service. For some people this meant they had one to one or even two to one staff support at times of their choice. Staff had mixed views about the levels of staff. Some confirmed there were enough staff to be able to flexibly meet people's needs whilst others thought staff numbers could be improved. This was discussed with the manager who said they would look into specific issues raised. They thought these comments related to private arrangements made by a person for additional staff support and not to the staff levels of Aspirations Southwest Adults.

People's medicines were managed safely. Their care plans described the support they needed to administer and manage their medicines. When people needed medicines to be given as required, protocols described the reason for giving this medicine, the maximum dose and when to call the GP for further advice. Stock levels of medicines were managed on the medicine administration record (MAR). Secure cabinets were being provided in people's bedrooms rather than communal areas if appropriate. Staff had completed training in the safe handling of medicines and were observed administering medicines before being

assessed as competent. Weekly audits of medicines administration raised any issues or poor practice which were investigated promptly. Medicines errors were discussed with staff during individual one to one meetings and they had access to additional training if needed.

Requires Improvement

Is the service effective?

Our findings

People's care and support had not always been effective due to inconsistencies around the support provided to staff individually and in teams. This had been recognised as a problem and staff were now working in dedicated services instead of across multiple locations. The new management structure had started to improve communication between staff teams, their line managers and the manager. Staff spoke positively about the plans which had been put in place to provide regular one to one meetings (supervisions) with their line manager and there was evidence that for some staff this process had started. Staff meetings had been arranged and handover meetings took place each day in people's homes. Staff commented, "We are going forward, but it is too early to say." This level of support and supervision for staff was not yet embedded and at this stage could not be evidenced as being consistently delivered. One member of staff said, "If the staff are happy then the service users will be happy."

People were asked about their preferences for the staff supporting them so they could be matched with staff who reflected their interests and personalities. For example, "fun", "open, bubbly people" and "can create a good atmosphere". People told us they were "happy" with their staff teams.

People were supported by staff who had the opportunity to acquire the skills and knowledge to meet their individual needs. Staff said they had all repeated the provider's induction course with representatives from the new management team. They told us, "Yes we have appropriate skills" and "We have ongoing training". New staff completed the Care Certificate and confirmed they shadowed their line manager until they had been assessed as competent to work with people in their homes. The Care Certificate sets out the learning competencies and standards of behaviour expected of care workers. The Provider Information Return (PIR) stated the views of people using the service were part of this process. Staff said they had completed refresher training when needed and were able to develop professionally completing the diploma in health and social care at all levels. Service managers were positive about the support they had received during their induction from a dedicated training mentor.

A representative of the provider told us further improvements included appointing a new head of training who would be based at Aspirations Southwest Adults and would co-ordinate training delivered by the provider, the local authority and NHS Trust. The PIR stated, "This would keep us up to date with local and national training" and "ensure that we are developing our workforce in a co-ordinated and consistent way". Staff had started training in positive behaviour support to develop their understanding of how to help people to manage their feelings and emotions. Staff also confirmed they had access to training specific to people's needs such as diabetes or epilepsy.

People made choices about their day to day care and support. They were observed talking with staff about what they wanted to do and making decisions which staff respected. They were being given choices about what to eat, drink and how to spend their time. People's care records clearly indicated what aspects of their care they were able to make decisions about such as activities and what they might need help with such as choosing to move to another house or taking their medicines. Staff were prompted to accept that people might make what they believed to be "unwise" decisions and they were to talk through the consequences of

their choices with them but to respect their ultimate decision.

People's care records stated how their capacity had been assessed in line with the Mental Capacity Act 2005 (MCA). The 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 had been supported with their tenancy agreements. Where people had lasting powers of attorney for health and welfare and/or property and financial affairs, evidence of this had been provided, and they had been involved where appropriate. Best interests meetings had been held when needed and records of any decisions made were kept with people's care records.

People occasionally had restrictions in place within their homes to keep them safe from harm. These had either been agreed with them or discussed in their best interests. They included locking the kitchen door, using a keypad or alarms in their rooms. The Court of Protection had authorised the deprivation of liberty for one person. People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA.

People's dietary needs had been identified in their care records. People living with diabetes had care plans which evidenced how this impacted on their diet. Staff had a good understanding of how to help people manage their sugar levels and alternatives were provided; the consumption of diet drinks was closely monitored. Staff described how they helped people to manage their diet having health snacks such as yoghurt or fruit so they could have a treat such as a cappuccino. People had access to the relevant health care professionals to help them monitor their condition; for example a chiropodist to check on the condition of their feet and an optician to annually examine their eyes. People with eating disorders were supported to eat a healthy diet. Their weight was monitored closely and they had been referred to the speech and language therapist for advice about their dietary needs and risks of choking. People who had allergies were also supported to buy food stuffs which they were able to eat. One person liked to go to the supermarket to choose gluten free snacks.

People told us they chose the meals they ate and then helped to cook the meals; "I do all my cooking for myself under supervision" and "the food is very good". One person was looking forward to preparing a spaghetti bolognese for tea. They were observed helping themselves to drinks. People decided when to have their meals and where to eat them. People said they liked to eat out occasionally and to also have take away meals.

Each person had a health action plan which detailed a history of their health needs, their current physical and mental health and also any medicines they were taking. Any appointments with health care professionals had been recorded here and the plans we saw had been reviewed in 2016. People's changing needs had been discussed with them and arrangements made to see the relevant health care professional. One person said they were going to see their optician and another person discussed with staff making an appointment to see their GP. People also had access to the local specialist learning disability and mental health teams when needed. Health care professionals said there had been a recent improvement in the working relationship with the services. The PIR confirmed, "People are supported and involved in the management of their health needs." Each person had a document which could be taken with them in an emergency which described their health needs, medicines and how best to communicate with them.

Good

Is the service caring?

Our findings

People had positive relationships with staff. A relative told us they valued the staff and thought that they related well to the person using the service. Health care professionals commented, "Lovely care workers." People were observed choosing to spend time in the presence of staff, enjoying their company, chatting confidently and sharing jokes. People were involved in choosing their staff team and giving feedback about new staff during their induction. Each month they had a meeting with staff and commented about the staff supporting them. Comments we viewed included, "Happy with current support and my staff as well", "[Name] makes me laugh, they are funny" and "Staff listen to me". Staff understood people well; some staff had worked with people for a long time and said they shared their knowledge about people with new staff. Staff were observed supporting people in line with their identified care and support needs. For example, one person preferred to be woken up and then given space to get up at their own pace. They disliked being rushed and staff respected this.

People's human rights were upheld. Their right to confidentiality was respected. Their personal records were stored securely in the provider's office. People's family and private life were promoted. People said they were supported to keep in touch with people important to them through visits, telephone, social occasions and meeting in private. People went to places of worship if they wished. They had identified in their care records whether they had any preferences about the gender of staff supporting them with their personal care; this was respected. People had access to age appropriate activities some of which were based in their local community in facilities open to the public. Staff had completed equality and diversity training and the Provider Information Return stated, staff have "an understanding of the importance of celebrating the differences between individuals, respecting and upholding their rights".

When people were anxious or upset staff responded quickly offering encouragement and trying to calm them. People's daily records evidenced the support staff had provided such as offering an alternative activity, a drink or time to talk with them. People's care plans described what might upset people and guided staff about what they should do to restore a sense of equilibrium. For example, staff were prompted to remain calm, offer reassurance and comfort. Staff spoken with had a good understanding of how to support people under these circumstances. Staff mentioned how changes to the staff team had started to result in improvements in people's behaviour and general well-being.

People were encouraged to express their views about their care and actively involved in making decisions and choices about their care and support. Their participation in the planning of their care was recorded in their care records. At their monthly chats with staff they talked about what they were happy with, what had improved and what was not working. Responses were positive or occasionally people had identified new objectives to work on such as catching the bus. People were also being invited to bi-monthly coffee mornings to meet with the manager and senior staff so they could exchange views informally on a regular basis. People had information about local advocacy services and would be supported to access an advocate if needed. A person confirmed, "The staff give me information when I ask for it."

People used different ways to communicate their needs. They had a communication profile which described

how they liked to express themselves whether verbally, using sign language, pointing to pictures or photographs or being shown objects. People were observed using pictures effectively with staff as well as sign language. Easy to read information had been produced for people using photographs and pictures to illustrate the text. For example, the complaints procedure and a decisions making guide. Communication profiles interpreted people's non-verbal behaviour for instance, by holding the hand of staff a person was happy for them to remain with them; if they pushed them away they wanted staff to leave them.

People confirmed they were treated with respect and sensitivity. A member of staff commented about the people they support; "I think we treat both the users with the upmost respect and compassion at all times". Staff listened patiently to people, giving them space to express themselves and respecting their wishes and feelings. People chose when to spend time on their own or with others; their right to privacy was respected. People were encouraged to be independent around their home, helping with the housework, laundry, shopping and cooking. People discussed with staff aspects of their daily lives which they would like to be more independent in such as catching the bus without staff support or trying new activities. Staff described how they supported people to achieve these by introducing simple tasks. Goals were reviewed with people to make sure they were still achievable, if they needed to be changed or had been met. Staff spoke with pride about people's achievements such as going on holiday, trying out Salsa or Zumba classes and learning to manage health conditions.

Requires Improvement

Is the service responsive?

Our findings

People's lifestyle experience was varied. Some people led full and active lives in their local communities taking advantage of local facilities such as the leisure centre, day centres, the cinema, bowling and theatre trips. Other people led more sedentary lifestyles going out for drives, to the shops and for meals; sometimes this was their choice but occasionally due to other circumstances. Activity schedules available to us indicated a significant amount of time doing "chores" around the home and people were observed helping with the cleaning. A representative of the provider said this would be reviewed. Inconsistent feedback from relatives, staff and people using the service also indicated not everyone had access to meaningful activities of their choice. A relative said, "Activities have declined of late." Occasionally this was said to be due to staffing levels. A member of staff said, "It's very hard on the users we need more staff". For those with limited access to activities, new schedules had been put in place and the staff all indicated a willingness to put these into practice. Staff recognised for some people community involvement was a long term goal. They described how they had gradually helped one person to tolerate possessions in their room which they chose to interact with, without destroying them.

People were supported to maintain relationships with people important to them. Relatives' experiences were inconsistent, some being made to feel really welcome when they visited and saying communication with staff was good, whilst others had not been greeted by staff or felt they had not been kept informed. However, one relative commented, "It seems to have settled and there are a lot of positives going on."

People's care was personalised and reflected their individual preferences, likes and dislikes and routines important to them. A person told us, "I do know my care plan but I'm not sure when it's reviewed." People's care records indicated how they had been involved in contributing to the assessment of their care and support. For example, some people had signed their records confirming their involvement and other people had talked with staff and others who knew them about what was in their plans. People's needs had been assessed by their funding authorities to make sure the service provided still met with their needs. Reviews of people's care had taken place with their relatives and social or health care professionals as well as staff. When people's needs changed their care records had been amended to reflect these. All care records we looked at had been reviewed and were up to date.

People's care records were individualised indicating how they wished to be supported. For many people their routines were extremely important to them. A relative commented, "Staff know him well and understand what he likes". Staff were observed responding to people's wishes, recognising when to offer support or when to stand back and encourage people to do things for themselves. People were observed having choice and control about their day to day lives and directing the care they wished to receive. For example, deciding when to have a shower or what activity they would like to do and when. People's diverse needs had also been considered and whether adaptations needed to be made to help them remain independent in their homes. Staff described the impact of people getting older and making sure the service they received was adapted to reflect their changing needs. For instance, making a referral to an occupational therapist for the provision of moving and positioning equipment.

People's care records were supplemented with behaviour plans which identified what might upset people and how staff were to support them by using distraction or other techniques to help them become calmer. The Provider Information Return (PIR) confirmed care records focussed on, "how to best support me" to offer "just enough support in order to promote and maintain independence". People's daily notes had been reviewed to make sure they provided a true reflection of their day to day lives. Prompts guided staff about what should be included so that an accurate record was kept.

People told us they knew how to raise concerns; their comments included, "Never had to raise a complaint but I would speak to the manager I think" and "Sort of". People talked through any issues they may have with their staff, at their monthly review of their care and support and when service managers visited them in their homes. Concerns were raised with staff as they happened for example staff were reported to spend too much time in the office. The PIR stated complaints information was provided to people in easy to read formats using pictures and plain English. In the past twelve months three complaints had been received. These had been thoroughly investigated and action had been taken to address any areas of the complaints which were upheld.

Requires Improvement

Is the service well-led?

Our findings

People's experience of their care and support was inconsistent and although this had been recognised by the provider, systems put in place to improve this had not yet all been implemented or embedded. For some people this meant they did not have access to leadf the lifestyle they would like to have; for example, having regular meaningful activities or having the right number of staff to help them achieve this. Whilst individual support meetings or supervisions had started for some staff this had not yet happened for all staff teams. At a time of change it was important to make sure all staff felt supported and able to move in the same direction as the service to provide consistency and continuity of care to people. A representative of the provider confirmed, "We are working towards one goal, consistency." The registered manager had left in February 2016 and the new manager had worked alongside her during their induction. Staff commented, "I think since the new manager has come on board there have been massive changes for the better" and "The manager overall is very new but you can see the changes happening already".

When people had accidents and incidents these had not always been recorded. The provider had recognised there was an under reporting of incidents when people were anxious or upset although accidents were being logged. In response, daily records had been changed to prompt staff to record any incidents and then to complete an incident record. This had been discussed with staff at staff meetings and they had training sessions about how these records should be completed. This work was on-going. The provider monitored accident and incident reports and would put Aspirations Southwest Adults onto a "watch list" if trends had developed for which strategies were not in place to resolve.

There had been significant changes to Aspirations Southwest Adults which included the management team and also the support for people in their homes. Staff spoke positively about the changes; "The new [service] manager structure has changed and the atmosphere has got much better" and "They have increased the service managers across the company". Staff said they felt more involved, communication had improved and they were feeling more supported; "It's too early to say, we can see from what they say we are moving forward, this can only be good." These views were reflected by health care professionals who said, "It's a promising start; it's early days, communication with general management needs to improve."

The manager's visions for the service were to make sure "People feel listened to, to have positive outcomes and safe care". Staff recognised she had put her "heart and soul into it" and "very much wants everyone to be happy, service users, staff and managers". The manager described how she was proud when staff shared successes with her such as health care professionals no longer wishing to be involved with a person because staff had supported them so well. She said she liked to share successes between the teams promoting good practice.

People were asked for their views about the service they received. Surveys were sent out annually and were due to go out to people in August 2016. As well as individual reviews of care, people were asked for their opinions at monthly reviews with staff and at bi-monthly coffee mornings with the manager and service managers. A newsletter was sent out to people and relatives keeping them informed about changes which had taken place and which were planned. People told us, "I've been quite content with the service I receive

and the staff are really good", "They ask me about my views" and "I think the company is well led with the support they give us".

Staff said they would raise concerns using the whistleblowing procedure. This is where a member of staff raises a concern about the organisation. Whistle-blowers are protected in law to encourage people to speak out. Staff had access to an independent system called "Safecall" which they could use to raise concerns, anonymously if they preferred. The Provider Information Return stated that Aspirations Southwest Adults, "promote a culture of openness across the services". Action had been taken by the provider in response to staff poor practice or performance issues through the disciplinary process.

Over the past twelve months there had been significant support from non-operational senior managers. They had completed quality assurance audits for all services provided to people during 2015 and actions identified improvements in a range of areas including care records, record keeping, medicines management and administration of finances. There was evidence of more intensive monitoring where there were concerns and additional monitoring and support being provided by senior managers. A representative of the provider said that a new compliance auditing tool was due back which also encouraged service managers to look at people's tenancies and deprivation of liberties. Additionally, quality audits would be mapping out what an excellent service looked like and assessing services against this. From this audit a strategic plan would be developed for Aspirations Southwest Adults.

The manager had completed the registered manager's induction with the local authority as well as continuing their professional development. They were aware of their responsibility to submit notifications to the Care Quality Commission. Statutory notifications are information the provider is legally required to send us about significant events. They were supported in their role by senior managers and by provider news bulletins and briefings. The Provider Information Return stated that the provider had been accredited by the Contractors Health and Safety Assessment Scheme and was a gold member of the British Institute of Learning Disabilities as well as consulting with Investors in People to register for their award. Aspirations Southwest Adults networked locally with the local authority and were involved with the workforce development group as well as local provider meetings. In this way the manager and staff were able to keep up to date with national best practice and changes in legislation as well as local initiatives.