Aspire In The Community Ltd

# Aspire in the Community - 13 Station Road

## Inspection report

13 Station Road
Lundwood
Barnsley
South Yorkshire
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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

Aspire in the Community – 13 Station Road is a residential care home in Lundwood near Barnsley. The home is registered to provide care for up to seven adults and specialises in supporting people with a learning disability and/or mental health needs. Accommodation is provided across a spacious five bedroom house and a separate two bedroom bungalow on the same site. All bedrooms are en-suite and both the main house and bungalow have a communal bathroom, living room, kitchen, dining room and utility room. The main house also had office space and facilities for staff.

The service was last inspected on 4 October 2013 at which time it was compliant with all the regulations we assessed. We inspected this service on 4 March 2016. The inspection was unannounced. There were four people using the service at the time of our inspection.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found that staff completed an induction and had on-going training to equip them with the skills and knowledge needed to carry out their roles effectively. Staff had training to enable them to keep people safe and effectively manage risks. People's needs were assessed and appropriate, proportionate risk assessments put in place to keep people safe. Staff showed a good understanding of the types of abuse they might see and what action they should take to raise concerns.

Appropriate checks were completed to ensure only people considered suitable to work with vulnerable adults had been employed and there were sufficient staff to meet people's needs. There were systems in place to manage and administer medication safely.

Staff understood the needs of the people they were supporting and there were systems in place to share information about people's changing needs.

Conversations with staff and our observations showed staff to be caring, person centred and knowledgeable about the needs of people using the service.

People using the service had choice and control over what and when they ate and people were supported to eat and drink enough and maintain a balanced and nutritious diet.

People were supported to engage in meaningful activities and access the wider community. The home encouraged people to maintain contact with family and friends. People had choice and control over how they spent their time.

There was a system in place to ensure people could raise concerns or make complaints if necessary.

People told us they felt the service was well-led and there were systems in place to monitor the quality of care and support 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.

Staff had training to enable them to identify and appropriately respond to signs of abuse.

The service had systems in place to assess and manage risks to keep people safe and prevent avoidable harm.

There were enough staff on duty to meet people's needs.

Medications were managed safely and in line with guidance on best practice.

### Is the service effective?

Good

The service was effective

Staff had training and on-going support to enable them to effectively meet people's needs.

People were supported to make decisions and their human rights were protected in line with relevant legislation and guidance.

People were supported to eat and drink enough and to maintain a varied and balanced diet.

Support was provided to ensure people had access to healthcare professionals to promote and maintain their physical health and emotional wellbeing.

### Is the service caring?

Good

The service was caring.

We received positive feedback that staff were kind and caring and had developed positive caring relationships with people using the service.

There were effective systems in place to support people to express their wishes and views.

Staff respected the privacy and dignity of people using the service.

## Is the service responsive?

Good

The service was responsive.

People's needs were assessed and personalised care plans put in place to support staff to provide responsive care.

Staff understood people's needs and used this information to provide responsive and person centred care and support.

There was a system in place to manage and respond to complaints.

## Is the service well-led?

Good

The service was well-led.

People we spoke with told us that the home was well-led and that the registered manager was approachable and supportive.

We observed that there was a positive atmosphere within the home and care and support was planned and provided in a person centred way.

There were systems in place to monitor the quality of the care and support provided.

# Aspire in the Community - 13 Station Road

**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 registered 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 4 March 2016 and was unannounced. There were four people using the service on the day of our inspection. The inspection team was made up of one Adult Social Care (ASC) Inspector.

Before the inspection we looked at information we held about the service, which included notifications sent to us by the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection and also contacted the local authority's safeguarding team. They told us that they did not have any concerns about the care and support provided at the home.

During the inspection we spoke with three people who used the service and two people's relatives who visited regularly. We observed interactions between staff and people using the service throughout the day and also observed a staff handover meeting. We had a tour of the service including communal areas and, with permission, looked in people's bedrooms.

We spoke with the registered manager and three staff. We looked at two care files and reviewed records relating to the management of medication, staff rotas, meeting minutes and records used to monitor the service, which included health and safety, maintenance records and quality assurance checks.

Good

# Is the service safe?

## Our findings

People we spoke with said "I feel safe, I am supported well", or used non-verbal forms of communication to indicate that they felt safe living at the home. Throughout our inspection we observed that people using the service were generally relaxed and acted in a way that showed that they felt at ease and at home in their surroundings. People appeared at times confident and outgoing, keen to approach and interact with staff and reacting positively towards them. This showed us that people felt safe living at the home.

The registered provider had a safeguarding adult's policy in place; however, we noted this needed up-dating to reflect changes in legislation introduced by the Care Act 2014. The registered manager was aware of this and told us it would be updated. In the interim, the registered manager explained that they were using information provided by the local authority to ensure staff had access to up-to-date information about how to safeguard vulnerable adults from abuse. We saw that staff completed safeguarding training and staff we spoke with showed a good understanding of the types of abuse they might see and appropriately described what action they would take if they had concerns.

Records showed that where safeguarding concerns had been identified, appropriate action was taken in consultation with the local authority safeguarding team. This showed us that there were effective systems in place to identify and respond to safeguarding concerns to keep people using the service safe.

We reviewed two people's care plans and saw that their needs were assessed, risks identified and risk assessments put in place to guide staff on how to manage these risks to keep people safe. We saw risk assessments relating to a wide range of activities of daily living including shaving, showering, eating and drinking and mobility and falls. Risk assessments were individualised and proportionate to people's needs and the level of risk. For example, one person using the service was identified as at high risk of falls. The associated care plan and risk assessment provided details about the level of support required, factors that increased the risks and the equipment and adaptations in place to reduce the risks.

Where people might display behaviours that needed to be managed in a specific way to ensure their safety; this information was recorded in their care plan. All staff completed 'Maybo' conflict management training to equip them with the skills needed to effectively respond if people were anxious or distressed. We saw care plans also contained 'safeguarding and conflict management risk assessments'. These provided very detailed and specific person centred information about triggers or situations which might cause people to become agitated or distressed, information about how people might react if they felt this way and guidance on how to de-escalate situations. This included instructions on the use of appropriate language, and words or phrases to avoid, and information about distraction techniques that had previously been successful. Staff we spoke with showed a good understanding of people's needs, the associated risks and how they were expected to respond to keep people safe.

Where accidents or incidents did occur, these were recorded and reports sent to the registered provider. We saw that there had been four recorded accidents or incidents since our last inspection. Although there had only been a small number of accidents and incidents, we spoke with the registered manager about

maintaining their own log of accidents, incidents and near misses to ensure that any patterns or trends could be identified and proactive steps taken to minimise future risks.

The registered manager showed us that they completed an annual environmental risk assessment alongside monthly audits to monitor the safety of the home environment. We looked around the home and saw that communal areas and people's individual rooms were clean, tidy and well maintained. Clear records were maintained of daily, weekly and monthly checks carried out for hot and cold water outlets, fire doors and call points and emergency lights. The registered provider had an up-to-date gas safety and electrical installation certificate. We saw that portable electrical appliances had been tested as well as portable fire extinguishers. The registered provider had an up to date fire risk assessment and we saw that the fire alarms were maintained and tested weekly. The registered manager told us they held fire drills every six months and showed us records of a recent fire drill completed in February 2016. This showed us that there were systems in place to help ensure the safety of the home environment for people who used the service.

The registered provider had an up-to-date business continuity plan documenting the arrangements in place to ensure that people's needs would continue to be met in the event of an emergency situation such as flooding, fire or a disruption in the electricity of gas supply to the home. We saw that the registered manager had taken steps to introduce personal emergency evacuation plans (PEEP's) although this work was still 'in progress'. PEEP's document the level of assistance people using the service would need to leave the home in the event of a fire.

On the day of our inspection there were enough staff on duty to meet people's needs. We observed that care and support was provided in a relaxed and unrushed manner and staff were consistently available and responsive to people's needs.

People using the service told us, "There's somebody here all the time if I ever need anyone" and visitors we spoke with said, "There's always plenty of staff on even when people are out." We reviewed rotas for the four weeks before our visit and saw that there was between two and three staff on duty during the day and one staff on duty at night. At the time of our inspection, no-one using the service needed support from two staff or required one to one support within the home. There was a risk assessment in place relating to lone working at night and an on call system if further support was needed.

Staff we spoke with did not raise concerns about staffing levels and told us that there were sufficient staff to meet people's needs and that sickness and absences were always covered. One member of staff commented, "Staffing levels are quite good. [The registered manager] or senior will come in to cover shifts and we have someone on call if we need it; shifts are always covered." Other staff said, "We phone other staff and have a senior on call if needed. We always get shifts covered, we are a good strong nit team and we will cover it." The registered manager told us that they would use agency staff if needed, however, said that this had not been necessary for a significant period of time. Staff we spoke with confirmed that they did not use agency staff and that staff covered shifts where necessary.

We reviewed records relating to three staff and saw that references were obtained and Disclosure and Barring Service (DBS) checks completed before they started work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. This showed us that there were systems in place to ensure that only people considered suitable to work with vulnerable adults had been employed.

The registered provider had a medication administration policy and staff received training on how to safely administer medication. One member of staff we spoke with told us how they completed the training, but then had to shadow and be observed administering medication before they were signed off as competent. Records we saw confirmed that competency checks were completed to ensure staff had the necessary skills to safely administer medication.

We reviewed how medications were managed within the home. We observed that medications were securely stored in a locked cabinet in each person's room. A daily record was kept of the temperature inside the cabinet and these records showed that medications were stored within safe limits.

Medications were supplied in blister packs along with printed Medication Administration Records (MARs). Blister packs are a monitored dosage system containing a 28 day supply of that person's medicines. MARs are used to document medication given to people who used the service. MARs we checked were filled in correctly. There were no gaps in recording and staff had used appropriate codes and provided further information on the back of MARs where necessary. We observed that handwritten entries on MARs were countersigned. This is good practice as it reduces the risk of transcribing errors. We observed that medication with a limited expiry had been dated when opened, so that staff could monitor and dispose of these where necessary. We checked the level of medication in stock against records held by the home and our random spot checks found that these records to be accurate.

Care plans contained details about the level of support people required to take their medication and showed that issues around consent had considered. One person using the service managed their own medication, they told us "I do my own medication, but staff check it for me."

Some medication is prescribed to be taken only when needed, for example, pain medication, which might not be needed every day; this is known as PRN medication. Where people were prescribed PRN medication, we saw that 'PRN protocols' were in place. These provided detailed guidance to staff on what the medication was used for, non-verbal indicators that might suggest the medication was needed, details about the desired effect of the medication and indicators that further doses may be required.

Good

# Is the service effective?

## Our findings

We reviewed the registered providers induction and training programme. New staff completed the registered providers induction, covering policies and procedures and the visions and values of the service, and an induction with the registered manager to meet people using the service, staff and to familiarise themselves with the home. Alongside this, new staff had to complete training the registered provider considered to be mandatory before starting any care work. This included training on food safety, fire safety, moving and handling, health and safety, first aid, infection prevention and control, safeguarding vulnerable adults and Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.

New staff then shadowed more experienced workers to equip them with the skills and knowledge needed to carry out their roles effectively. One member of staff told us, "They didn't throw me straight in, I did two weeks of shadow shifts and even then they asked if I needed more." Following this, staff we spoke with said they did not provide immediate assistance with medication or personal care and explained that they had to get to know people and earn their trust first. This showed us that the service had a system in place to support new staff gain confidence and experience in their roles.

In addition to induction training, staff had to complete refresher training either annually, every eighteen months or every three years depending on the course. We reviewed the registered manager's training matrix, which they used to identify when training needed to be updated. This showed us that staff received on-going training throughout the year to update their knowledge and skills. We saw that this was an effective system as staff we spoke with were knowledgeable about their roles and responsibilities. One member of staff told us, "The training we have had is more than sufficient for our needs here, we are inundated with training, if we are not doing something we get put on training." We saw that a number of staff had completed additional non-mandatory training, including 10 staff that had been supported to complete a Learning Disability Qualification (LDQ). This is an independent qualification providing specialist knowledge and guidance on best practice with regards to supporting people with a learning disability. This showed us that the registered provider was committed to supporting staff to gain the skills needed to provide effective care and support.

Staff we spoke with said they had supervision with the registered manager approximately every three months to discuss any concerns they might have, talk about training and personal development, their roles and responsibilities and any support needs. The registered manager showed us a record of how they monitored supervisions completed throughout the year and when supervisions were due. We could see from this that supervisions were carried out throughout the year and staff received regular supervisions. Staff we spoke with also consistently told us that the registered manager was approachable and they could speak to them or ask for additional supervisions in between scheduled meetings if needed. This showed us that there were effective systems in place to support staff in their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered provider was working within the principles of the MCA and DoLS. At the time of our inspection two people using the service were subject to DoLS and a further application had been submitted.

One person using the service was supported by an Independent Mental Capacity Advocate (IMCA) and we saw records of their regular visits. An IMCA is someone who supports a person so that their views are heard and their rights are upheld. The registered manager understood the role of IMCAs' and general advocacy services and had contact details available if other people using the service required advocacy support.

Staff we spoke with had a basic understanding of the MCA and their role in supporting people to make decisions. Staff gave us examples of how they used picture cards and accessible information to explain options and interpreted non-verbal forms of communication to understand people's wishes and views. Staff had a good understanding of people's rights to make unwise decisions. Where there were concerns about people's ability to make decisions, we saw that mental capacity assessments had been completed and, where necessary, best interest decisions made. Best interest decisions are decisions made on a person's behalf where they have been assessed as lacking capacity. We saw mental capacity assessments and best interest decisions in respect of providing support with personal care and assisting with medication. We saw appropriate records were kept in relation to these decisions.

Care plans contained nutritional assessments detailing the level of support people needed to ensure they ate and drank enough. Care plans also recorded people's food allergies as well as detailed information about food likes and dislikes.

Staff we spoke with showed us how they planned weekly menus using pictures of food and meal choices to support people to decide what to eat. This was important as some people used non-verbal means of communication and this allowed them to be involved in deciding what to eat. Staff told us that they encouraged people to prepare their own meals and drinks, but provided support where necessary. We observed that there was a range of food available in the home, including fresh fruit and vegetables from which staff or people using the service could prepare meals and snacks. A relative told us, "[Name] can help themselves to food, there's always a bowl of fruit on the table and snacks available."

Care plans contained food and fluid charts so that staff could record what people ate and drank. The registered manager told us and care plans confirmed that people using the service were not at high risk of malnutrition or dehydration and this was used purely as a monitoring tool to ensure that people using the service had a nutritious and balanced diet. We saw records that showed staff had prepared a variety of meals in the week before our visit to cater to people's specific needs and preferences. We spoke with the registered manager about recording daily fluid totals on fluid charts, as current records only documented "W" for water or "C" for coffee and not the amounts drunk.

Staff we spoke with understood people's specific nutritional needs and allergies and showed us adapted crockery and cutlery that people used to maintain their independence. People were regularly weighed and these records showed that people were supported to eat enough.

Care plans documented information about people's past medical history, current health needs, prescribed

medications and contact details of healthcare professionals involved in supporting them. Visits by healthcare professionals were recorded on a 'professional's visit matrix', which evidence that people using the service had been seen by their G.P's, chiropodists, opticians, psychiatrists and other healthcare professionals. For each of these visits further information was recorded in the person's medical health about the reason for the appointment the outcome and details of any follow-up action needed including changes to that person's care plans. These records showed us that people using the service were supported to access healthcare services to promote and maintain good health.

Good

# Is the service caring?

## Our findings

People we spoke with told us that they felt that staff cared about them and treated them with kindness. Other people used non-verbal means of communication to indicate that they felt safe and comfortable living in the home and with the care and support provided by staff.

We observed a number of positive interactions throughout our inspection between staff and people using the service. Staff were observed to be warm, friendly and attentive to people's needs. We observed staff acknowledging people, making eye-contact and engaging with them as they moved around the home.

Relatives we spoke with consistently told us that staff were kind and caring with comments including, "The staff are A1. They are very good, very patient with them. Each member of staff is really nice and friendly."

Staff told us they felt other people who worked at Aspire in the Community - 13 Station Road cared about the people they were supporting. Comments included, "People care very much, it's not clinical, it's like a family feeling" and "Staff are caring you can tell by how they treat people, the choices they give, it's all about the service users."

We asked staff how they got to know people using the service. One member of staff said, "I speak to staff and family member to get to know people. It's also being around service users, even people who use non-verbal communication, you can tell through their body language what they like – you get to know people." Other staff told us how there was information in people's care plans that helped them to get to know people. We reviewed people's care plans and saw that they contained a range of person centred information about people's likes, dislikes, family relationships, hobbies and interests.

We observed that there was a small staff team working at the home. Staff told us that they routinely covered shifts to avoid the need for agency staff. This ensured that there was a consistency of care and supported both staff and people using the service to get to know each other. Meanwhile we observed that staff had time to spend talking or going out with people using the service. As a result, we saw people being cared for by staff that understood their needs, recognised what was important to them and cared about their wellbeing.

People using the service were supported and encouraged to express their views and be involved in decisions about the care and support provided. One person told us, "I make all my own decisions." Staff we spoke with said, "People can stop in or go out, we encourage people to be as independent as they can be" and described the support they provided to encourage people to be independent and make decisions.

Staff and the registered manager showed us a range of communication aids they used to support people to express their views and be involved in decision making. These included pictorial reference cards and 'easy read' information. Easy read information is designed for people with a learning disability and is a way of presenting plain English information along with pictures or symbols to make it more accessible. The registered manager showed us how they used a database of accessible information to support people using

the service to understand information and to support them to make informed decisions. For example, we saw that one person's care plan contained accessible information leaflets that were used to explain what would happen at medical appointments. This was used to help the person decide if they wanted to have a certain procedure or not.

Staff also described how they used their familiarity with the people they were supporting to understand non-verbal communications. We saw staff enabling people to do what they wanted to and could see that the people using the service expressed their views and were listened to.

Staff we spoke with understood the importance of maintaining people's privacy and dignity and explained how they made sure people's doors were closed and their curtains shut when assisting with personal care. People using the service said, "If I want my own space I go to my room, they always knock before coming in." We observed that the care and support provided in communal areas maintained people's dignity and we observed staff knocking on people's door before entering their rooms. We observed that conversations and support provided in communal areas was appropriate and respectful.

Good

# Is the service responsive?

## Our findings

We reviewed two people's care plans and saw that detailed assessments were completed, which formed the basis of people's care plans. Assessments gathered information about people's medical history, current health needs, medication, family involvement, support needs, communication needs and detailed person centred information about people's likes, dislikes and personal preferences. This information was used to create detailed care plans providing guidance to staff on how best to meet their needs. There was evidence that information from relevant health and social care professionals was sought and advice and guidance incorporated into people's care plans and risk assessments.

Care plans also contained a one page profile of accessible information about the person, their likes, dislikes, hobbies and interests as well as details about how best to support that person. This information was person centred and provided a quick reference guide to help staff to understand the person and the things that were important to them.

The registered manager told us they aimed to update the care plans and risk assessments every three months or more often if needed. The care plans we looked at had been reviewed and updated recently. We saw evidence that meetings were held and people using the service were encouraged to attend and participate in reviewing the care and support provided.

We looked at the systems in place to ensure staff had up-to-date information about people's changing needs. We saw that daily records were maintained of the care and support provided to each person using the service. We observed the afternoon handover meeting between staff on the morning shift and staff working that afternoon. We saw that people using the service were discussed, an update given and important information about people's needs handed over. During this meeting we observed staff talking about previous and upcoming events, demonstrating that they had a good up-to-date knowledge of people's current circumstances.

From our observations and conversation with staff, it was clear that they had an understanding of people's needs and what was important to them and used this information to provide responsive person centred care to that individual. We observed that staff treated people as individuals and supported and validated people's individual preferences and choices.

People told us that they were able to make choices, such as what activities to take part in, what to eat and drink and what time to go to bed.  One relative explained that the home was proactive in supporting people to go out commenting, "They've got a life now, they go shopping, go on holidays, it's a lovely home." They explained how staff supported and encouraged their relative to decorate their room, recognising how important this was to the person using the service. With permission, we looked in two people's rooms and saw that they had been decorated and personalised and that the staff had acknowledged and validated people's personal preferences.

Care plans contained an activities schedule which recorded planned activities throughout the week. On the

day of our inspection people using the service went out at different times throughout the day and were supported by staff where necessary. Whilst there was some routine, for example, around time spent at day centre services or with one to one time for activities, we also saw that people were encouraged to be independent and have choice and control over how they spent their time. This was reflected in the encouragement provided for people to pursue their own interests and hobbies.

People were also encouraged and supported to stay in touch with family and friends. We observed that staff liaised with people's relative or carers about visits or trips out and supported people to maintain important family relationships. It was clear that there were good relationships between people who used the service, staff and people's family or carers. Relatives we spoke with told us that there was good communication from staff, and similarly, told us they felt able to ring the home at any time to discuss concerns or ask questions. One person we spoke with told us, "The communication is really good." Relatives we spoke with also said, "We are always made to feel very welcome when we visit."

The registered provider had a policy in place detailing how they managed and responded to complaints. We observed that a copy of the complaints policy was displayed in the main entrance of the home along with copies of an accessible 'easy read' form to guide people using the service on how to raise concerns.

People we spoke with told us that they had not needed to complain, but felt able to raise concerns if needed. One relative told us, "It's absolutely brilliant; I've never had any reason to complain." The registered manager maintained a complaints log recording when a complaint was received and this was signed off when the complaint had been appropriately dealt with. There had been one complaint received in 2015 and no complaints in 2016. We saw that the complaint had been appropriately investigated and a response provided in a timely manner. The home and staff had also received a number of compliment cards, but these were not always dated so we could not be sure whether they were received. The registered manager showed us a compliments log they had recently introduced so that they could record compliments received in future.

Good

# Is the service well-led?

## Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and as such the registered provider was meeting this condition of their registration. The registered manager was supported by senior support workers in the management of the home.

We asked people whether they thought the home was well-led, comments included, "They are very good, it's like a family home" and "I can't fault it…it's a lovely home."

We observed that that there was a positive atmosphere within the home. We saw that interactions between people that used the service, staff and the registered manager were relaxed and informal. Care and support was provided in a coordinated, unrushed and attentive manner throughout our inspection.

Staff we spoke with told us they felt that the home was well-led and we received consistently positive comments about the management of the service. One member of staff told us, "I have nothing but respect for the management, the service users are paramount, we put the service users first" whilst another said, "[The registered manager] does a very good job; they are fair, listen to you. I they think they are a great manager. They are not only in the office all the time; they are on the 'shop-floor' as well."

The registered manager showed us the home's 'statement of purpose'. This contained clear information about the visions and values of the service, which was communicated to new staff through their induction.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection. We found these were stored securely, well maintained and updated regularly. We found that care plans and other records were detailed and comprehensive and we saw evidence that they were regularly updated; however, we spoke with the registered manager about ensuring that information in care plans was not repeated in order to improve accessibility and ease of use for staff.

We spoke with the registered manager about how they monitored the quality of the care and support provided. They told us, "If we observe something, we deal with it." We observed that the registered manager did provide direct care and support to people using the service, including covering sickness and absences. We could see this was an important system used to monitor the quality of care provided, support staff and role model best practice.

In addition to this informal quality assurance, the registered manager completed competency checks for staff administering medication to ensure that staff were working in line with guidance on best practice. The

registered manager also showed us a monthly quality assurance checklist they completed recording when certain actions, for example fire safety checks or a team meeting had been held and when audits such as the kitchen audit had been completed. The registered manager told us that the pharmacy visited approximately every three months to complete an audit of medication management within the home and we saw records of their last audit completed in November 2015. The registered provider had also commissioned an external independent quality assurance audit, which was completed in September 2015. Where issues were identified we saw that steps had been taken to address these to drive improvements within the home.

The registered manager told us the last 'Service User and Relatives Questionnaire' completed to gather feedback about the service had only received one response. The registered manager told us instead they had decided to organise quarterly 'Parents and Carers Meeting'. We saw minutes for the first of these meetings held in November 2015 and could see that they were used to meet and share information and gather feedback about the home.

The registered manager held regular team meetings. These had been monthly, but had recently changed to every two months to improve attendance. We saw minutes for the last team meeting held in February 2016 and saw that seven staff had attended and topics discusses included team work, keyworker roles, the rota and training needs. Minutes were produced so that staff unable to attend knew could keep up-to-date with what was discussed. This showed us that team meetings were used to effectively share information and to discuss improvements within the home and with the care and support provided.