Independence Matters C.I.C.

Personal and Community Support Services Personal Assistant Services South

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Personal and Community Support Services Personal Assistant Services South is a domiciliary care agency which provides care and support to people living in their own home.

At the time of this inspection care was provided to 13 people with a range of physical, mental and learning disability needs.

This comprehensive inspection took place on 25 July 2016 and was announced. It was carried out by one inspector.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the agency. 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. There was a registered manager in post at the time of our visit.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed by the local authority and care would be provided in people's best interests. The service provides care to people with learning disabilities and people with dementia. However, the provider had not yet developed their own assessment of people's mental capacity and it was therefore unclear how people's day-to-day care was being provided in their best interest. In addition, the provider had no policy in place in relation to the application of the MCA. Following our visit, the provider told us that, as a result of our inspection, that they had made arrangements to ensure people's rights were protected in accordance with the MCA. Staff were trained and knowledgeable about the application of the MCA.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind staff who they liked. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

People were supported to increase their integration into the community; they were helped to take part in recreational and work-related activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

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 individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees. This was before they were deemed suitable to look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was not acting fully in accordance with the Mental Capacity Act 2005 [MCA] legislation to protect people's rights. People's capacity to make decisions about their day-to-care was not assessed. There was no policy guidance in relation to the MCA. However, the provider was taking action to rectify these deficiencies. This was to ensure that people's rights were always protected in line with the MCA.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual physical and mental health needs were met.

People were supported to take part in activities that were important to them.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to ensure that staff were providing people with safe and quality care.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

Personal and Community Support Services Personal Assistant Services South

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 25 July 2016 and was announced. It was carried out by one inspector.

The provider was given 72 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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.

Prior to the inspection we made contact with a physiotherapist: this was to help with the planning of the inspection and to gain their views about how people were being looked after.

During the inspection we visited the service's office where we spoke with the registered manager; two team managers and three members of care staff. We also spoke with two people who use the service and three people's relatives.

We looked at three people's care records, medicines administration records and records in relation to the management of staff and management of the service, including audits and minutes of meetings.

Due to their complex communication needs some people were unable to verbally tell us their views about their experience of being looked after. Therefore, we observed care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People were kept safe as far as possible from the risk of harm. We saw that people were treated well by staff members who were kind and attentive. People freely interacted with members of staff and were comfortable in the presence of members of staff who were looking after them. People's relatives told us that they felt their family member was kept safe because of how they were treated and looked after. One relative said, "They [staff members] are lovely and are very nice with [family member]." Another relative added that the staff made sure that their family member had their call alarm bracelet on. They said that this was so that their family member would be able to use it when they were alone and needed assistance.

Other procedures were in place to keep people safe from the risk of harm. The provider told us in their PIR that, "All staff have mandatory safeguarding training and know how to report concerns." Members of management and care staff were able to demonstrate their knowledge acquired from their training and described the types of harm people may experience and what action they would take if such events took place. One member of care staff and both team managers told us that there was a local authority safeguarding number they would use. A member of care staff said, "If I saw anything untoward, I would speak to [name of team manager]. We've also got on-call [provider staff support system] numbers and safeguarding numbers." In addition to this, members of management and care staff were able to describe how they would know if someone was being harmed. One team manager said, "There could be changes in the person's behaviours. A person could become withdrawn and this would be out of their character. If it is physical abuse you could see cuts, bruises or abrasions."

The provider wrote in their PIR about how their recruitment procedures protected people from unsuitable members of staff. The PIR read, "Enhanced DBS [Disclosure and Barring Service] checks, references and health questionnaires are all completed prior to an offer of employment." The registered manager described the recruitment process, which included the involvement of people and staff members. At pre-interview stage, prospective staff were observed to assess their ability to interact with staff and people who use the service. People and staff were enabled to provide the management team with feedback about prospective staff. This feedback included the quality and personality of the prospective member of staff.

The management team told us that, as part of the recruitment process, the interview would assess the suitability of the prospective staff member's values. This included, for example, the values of dignity, caring and respect. One team manager said, "We do a values-based interview regarding people's [prospective staffs'] experiences. Their commitment; respect; empathy. How they have learnt from their own experiences." One member of care staff told us about how they were recruited into their role. They said, "They [management team] asked me certain types of questions. Gave me different types of scenarios and what experience I had got." They also added that they were subjected to all the required checks before they were allowed to work. These checks included a satisfactory DBS check; two written references; proof of identification and completion of an application form. One team manager told us that the application form detailed the prospective member of staff's previous employment history. They said, "We ask for an explanation if there has been any gap in their employment history."

We checked and found that people were looked after by sufficient numbers of staff. People's care records detailed the number of staff that they needed to keep them safe and to meet their needs. This included, for example, one-to-one and two-to-one staff ratio to support people going out in the community. Members of care staff and one of the relatives agreed that there were enough staff to look after people at all times. We saw that people were relaxed and had members of staff available to talk to and ask for their support when this was needed.

Measures were in place to cover staff absences and to ensure that people received a continuity of care. The registered manager said, "We are fortunate as we have a relief bank of staff and they are trained to our standard and have bespoke training if needed." One relative told us that their family member received care from the same members of staff. They also told us that the staff member was punctual to ensure that their family member took their medicines at the correct prescribed time. They said, "They [the staff] are coming at the time that we have specified." Another relative told us that staff were not rushed and had the time to spend talking to their family member. They also told us that their family member, who was living with dementia, had "regular" members of care staff. They said, " [Family member] recognises their faces and has developed a very nice relationship with them." This showed that there were enough staff to meet people's individual needs and provide them with a continuity of care.

People's risks were assessed and measures were in place to mitigate the risks. One team manager said, "Risk assessments are centred to the customer [person using the service]. Measures are in place according to the level of the risk. We assess if a hoist is needed when a person goes swimming, and assess the access to the pool. We only use a public swimming pool where there is a lifeguard." One person's care record showed how their behaviours, which posed a health and safety risk to others, were managed. The actions included ensuring that there were sufficient numbers of staff available. We saw one person, who had behaviours that challenged, being supported by a two-to-one ratio of staff. We also found that the staff members followed the risk assessment when escorting the person. Another example of managing people's risks was found in each person's care file; these contained a personal emergency evacuation plan. This was in case there was a need to keep people safe in the event of, for instance, the outbreak of a fire. This showed us that people were kept as safe as reasonably as possible.

We checked and found that people's management of their prescribed medicines was of a safe and satisfactory standard. One relative told us that their family member had their medicines at the time that they were prescribed. Another relative said, "[Family member] is reminded [by care staff] to take [family member's] medicines."

Our examination of two completed and accurate medicines administration records found that members of care staff had supported the person to take their prescribed medicines. One person was prescribed medicines to manage their health condition. The person was kept well and free from seizures. This indicated that they were supported to take their anti-epileptic medicine as prescribed.

People were also enabled to be independent in the management of their medicines; the records demonstrated that assessments and checks were in place. This was to ensure that people were safe with this self-care practice and that they had taken their medicines as prescribed. Care staff told us that they had attended training in managing people's medicines. They also added that they were assessed to be competent before they were allowed to support people in taking their prescribed medicines. One member of care staff said, "Medication training is renewed regularly and we get 'spot checked' on that." Their records confirmed that staff were trained and assessed to be competent in supporting people with managing their prescribed medicines.

Good

Is the service effective?

Our findings

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. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. 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.

The provider told us how they ensured people's rights were protected: they said in their PIR, "Best Interests - Independence Matters [name of the registered provider] has a robust policy and procedure in place applying to all customers [people who use the service] here 'best interests' are exercised on their behalf. Best interests meetings are held and all relevant information is shared with multidisciplinary teams in the best interest of the customer [person using the service]." The registered manager confirmed that 'best interests' meetings were held. However, there was no policy guidance or written procedures in place to guide staff in the application of the MCA, which includes a 'best interest' approach. Following our inspection the provider told us more about this and said, "The company have (sic) used the MCA Act and Code of Practise as their guides. Independence Matters does accept that a stand-alone policy, procedure and their own example guiding documents to compliment the Act and code will give improved support to staff in the application of the MCA and best interest decisions." This showed that the provider was accepting that improvements were needed.

Members of care staff were trained in the application of the MCA and had an understanding of this. One team manager said, "Never assume a person does not have capacity and allow them to have a choice. To use less restrictive approaches if they do not have capacity." One member of care staff said, "We are not to assume that people cannot make decisions. We help them with making decisions for them." However, it was unclear how people's level of mental capacity was assessed and how people were supported in making decisions. The registered manager advised that there was no provider assessment in place to assess people's capacity to make informed decisions about their day-to-day care. This would include, for example, informed decisions about taking prescribed medicines, choosing to intentionally lose weight, or attending an appointment with a GP or dentist. The registered manager told us that MCA assessments were only carried out by the local authority, if needed. They said, "We refer them [people] to the social worker to ask them for an MCA assessment." They added that the majority of people were able to make decisions for themselves. However, people who were receiving the care had complex conditions which could affect their ability to make such decisions. Therefore, we were not fully confident that, without proper policies and structured provider assessments in place, that people's rights were fully protected. The registered manager agreed that this was an area for improvement. Following our inspection the provider wrote to confirm that

people were supported to make more complex decisions. However, they agreed that they did not assess people's capacity to make day-to-day decisions. They wrote and said, "Daily activity decisions are not generally documented only significant events. The company is drafting example documents to help guide staff and customers [people who used the service]." This showed that the provider acknowledged that improvements were needed.

The provider made sure that people were looked after by trained staff. The community physiotherapist told us that they felt staff were competent to be able to look after people. Members of care staff told us that they had received training to do their job. This included induction and on-going training. Induction included a new staff member observing ['shadowing'] a more experienced member of staff at work. One relative told us that, by means of introduction to their family member, a new member of staff had 'shadowed' a more experienced colleague.

Regarding on-going training one member of care staff said, "The training is excellent. You can't fault the training." One team manager told us about the benefits they received from attending training in dementia care. They said, "The dementia training was very good. The types of dementia and what causes it. It was about the basic ways of supporting someone with dementia. To keep them independent and safe without restricting their freedom." They gave an example of how they effectively applied their training into practice. This was by using a picture method of communication to help remind a person of their previous living arrangements and that this "seemed to settle [person]." A number of training topics which staff attended included: moving and handling; autism; fire safety and food hygiene. The registered manager said, "The training is service specific so staff attend training in autism if they are looking after people with autism."

Staff were supported to do their job by various staff management methods. These included one-to-one supervision and appraisal of their work performances. One member of care staff said, "I have one-to-one supervision to see if I am still happy. How I'm getting on. Anything I need such as training. I had an appraisal about a month ago and it was my yearly appraisal." They also added that they felt supported because, "They [management team] treat you like a human being. Here you are recognised for what you have done." This told us that staff were supported to make sure that that they were able to do their job.

People's nutritional needs were met. The provider told us in their PIR how they ensured people's nutritional needs were met: they wrote, "Staff work with carers [people's relatives] in supporting special diets. Good hydration ensured by enabling customers [people] to make own drink choices at regular intervals throughout the day." They also wrote, "We work with dieticians promoting healthy eating/exercise." The community physiotherapist told us that the staff had enabled a person to eat more healthily. They told us that," Staff are working jointly with family and health services to manage [one person's] weight issues and encourage healthy eating/activity." One relative said, "They [care staff] remind [family member] to eat and drink. They help [family member] to make a sandwich and leave it in a prominent place for [family member] to eat later. They prompt [family member] to eat and make sure that [family member] has got an evening meal." Another relative said, "The staff make sure [family member] has drinks. They make a cup of coffee and squash." One person's daily records showed that the person had a range of food and drink to eat. This included having meals out as part of their planned recreational activity programme. We saw they were offered a choice of food and drink. One member of care staff presented a choice of fruit and breakfast cereals in a visual form for the person to be able to make their choice. An alternative choice was offered when the person did not eat their first choice of breakfast cereal with added fruit.

In their PIR the provider explained how people were helped to keep well and said, "…staff accompany customers [people who use the service] to attend healthcare appointments: GPs, hospital (supporting during hospital stays if required) and dental visits." The community physiotherapist told us that staff would

follow their health care advice and said, "Sometimes staff need persuading to try something new or an alternative approach but if they see the benefits they will embrace the new activity/change." One relative told us that the staff supported their family member to attend GP appointments. Care records showed that people's behaviours that challenged were monitored and GP advice and treatment was sought. The registered manager told us that one person's relatives were advised to make an appointment with their family member's GP and this advice was taken. This told us that people were supported to maintain their health.

Good

Is the service caring?

Our findings

We checked and found that people were at the heart of the delivery of the service. There was an introduction process in place to 'match' members of care staff with individual people. The registered manager said, "Staff always shadow more experienced staff. This is for several reasons. To ensure that the customer [person using the service] likes the member of staff and has the same qualities, values. We try and match staff who 'click and gel' [with the person they would be looking after]". One member of care staff said, "I 'shadowed' a couple of more experienced members of staff. I was introduced to people before I supported them." The provider told us how they aimed to match staff with people to forge caring relationships between both parties. Their PIR read, "We work hard to match customers with a core staff group in a professional working relationship that is highly effective."

We saw that people had a good relationship with members of staff who looked after them. One person was laughing with the staff members. Another person had a lot of praise for the member of care staff who was looking after them that day. Relatives also had positive things to say about the staff. One relative said, "Staff are lovely and they take time to speak to [family member]. They chat to [family member] about [family member's] likes and dislikes and where [family member] comes from."

The community physiotherapist told us that people's rights to privacy and dignity were valued and respected. They also said that staff cared about people who they looked after. Members of care staff were clear about their roles and responsibilities in caring after people. One member of care staff told us how they ensured that a person's gender preference was valued. They said, "I think [person] and their mum and dad prefer [person] to have a female [member of care staff]." We saw one member of care staff hand a disposable towel to a person. This was so that they were able to independently wipe their face and hands after they had eaten. We saw that staff members offered people choices of where they wanted to sit, eat and places where they wanted to visit.

In their PIR the provider told us how they cared for people and wrote, "We uphold a culture that puts customers [people who use the service] at the centre of their service, involving people of significance in the person's life where appropriate, to ensure needs are being voiced and met." One relative told us how their family member's choices were valued. They said, "The staff respect [family member's] choices of when [family member] wants a bath or shower and to have their hair washed." They also added that the benefits of the care provided was to support their family member to independently live at home. They said, "It's [care] is keeping [family member] in their home longer and in familiar surroundings. It also keeps [family member] company." The relative also explained how they, too, benefitted from the care and said, "We couldn't do without it."

One person told us how their therapeutic one-to-one care had increased their level of confidence. They said, "The care is about confidence building. Now I can get a taxi. I can now also cook. Lasagne, pasta, burgers. Before I couldn't swim. I used to be terrified. Now I can do this. I have things to look forward to. I have made friends and been to my first party. I used to be so self-conscious. Now I am happy." Their relative said, "[Family member] is coming out of their shell. [Family member] looks forward to going out. A massive

improvement."

The registered manager told us that advocacy services had been used to support people in making decisions about their care. They said, "Advocacy was used to help a person with their finances and during their reviews. It was to represent the person on a neutral basis. We didn't want to be seen to be biased." Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

The provider told us in their PIR that they obtained an assessment from external agencies who were paying for the person's care. The information detailed in the assessment formed a basis for the developing care plan. Relatives told us that they were involved in the assessment process to determine if the provider was able to meet the needs of the person. One relative said that they were, "originally involved" in setting up their family member's care package.

People's new and on-going needs were assessed and reviewed by all staff members. There was a process in place for care staff to inform the team managers of any changes in people's care needs. This process included discussion about people's individual needs during team meetings or during monthly reviews of people's planned care or sooner. Care records and risk assessments were up-to-date to ensure that staff had the right guidance to meet people's individual needs. One member of care staff told us that they found the care plan guidance was easy to follow. Induction provided staff with the opportunity to familiarise themselves with the contents of people's care plans.

The PIR detailed how people's needs were met which included, "As a team, we are consistent, co-ordinated and responsive to customer needs. We can adapt our support timing and we are a listening service and understand that we need to flex [be flexible] support around change." The community physiotherapist gave an example of how one person's individual, complex mental health needs were met by care staff. They described how this had improved one person's level of communication and confidence. This had enabled the person to make choices and become more integrated into the community. The community physiotherapist added, "I believe the staff have a good understanding of the service users [people] they work with as support seems consistent…"

One relative told us that their family member's care was "going very well" and told us their reason why this was. They said that their family member was hard of hearing and said, "[Before the care] I was ringing [family member] but often [family member] couldn't hear the 'phone. Now it's great when I ring because [family member] hears the 'phone and I can speak to [family member]." This was because care staff supported and reminded their family member to continually wear their hearing aids. One member of care staff told us about what caused another person to become unsettled. They said, "It could be noise or overcrowding or changes in staff. The strategies used are taking the person back to their vehicle to calm down. Or offer drinks. It doesn't happen very often as we have a very strong core team of staff as we know when the signs, or triggers, start to appear." We saw that the person was being reassured when the loud noise of an overhead airplane was heard. We also saw that both staff members gave the person space when walking and sitting. These findings showed how people's individual needs were met.

Reviews were carried out regarding people's planned care and these included the involvement of the person and people who mattered to them. Relatives told us that they were actively included in such reviews. The anecdotal evidence they provided to us demonstrated that they were kept fully up-to-date with their family member's care and progress. Changes made as a result of the reviews included obtaining advice from health care professionals to improve people's behaviours that challenge and intentional weight loss.

People were supported to take part in social, recreational and work-related activities. The aim of this was to promote people's sense of well-being and reduce their risk of social isolation. One relative told us that their family member "looked forward" to having visits from care staff. They said that, during this time, the care was also a "social event." One person told us that they were supported to attend music sessions; work as a volunteer and go swimming. Another person also went swimming with support from staff. Other recreational activities included attending the on-site day-services and attending social clubs where people had made friends.

There was a procedure in place which enabled people to raise their concerns and complaints. People's relatives, and one person who was able to verbally tell us, knew who to speak with if they were unhappy about something. One relative told us that they had spoken with one of the team managers and was satisfied with their response. Another relative told us that they knew who to speak with if they were unhappy about something, but had no cause to do so. Each person had information about what to do if they were unhappy about something. The information contained contact names and numbers of the management team and the local authority. The provider's complaints log demonstrated that few complaints had been received and all had been resolved to the satisfaction of the complainant. The registered manager advised us that there were no emerging patterns from the complaints to improve the quality of people's care.

Good

Is the service well-led?

Our findings

There was a registered manager in post when we visited. Members of staff had positive comments to make about the leadership style of the registered manager. One member of care staff described the registered manager as "approachable." Another member of care staff expanded on this and said, "[The registered manager] will listen to what we want to say and is very understanding. And supportive." The registered manager told us how they listened to what staff had to say. They said, "As part of the [staff] appraisals we include a 360-degree feedback [so that staff can tell managers their views about them]. We are trying to ensure that we are all working the best so staff can challenge colleagues and management if they feel they are not working to the values or standards expected of them." This told us that there was a democratic and transparent culture operating in the management of the service.

The provider's whistle-blowing policy also provided an example of the transparent culture of the management of the service. Members of staff were aware of this policy and knew when this was to be used. One member of care staff said, "Whistle-blowing is if you see anything untoward then you would report it to [name of team manager]. We've also got safeguarding numbers to use." One team manager told us how the whistle-blowing procedure helped staff. They said, "The whistle-blowing policy can provide staff with support and confidence to blow the whistle."

Quality assurance systems were used to ensure the safety and quality of people's care. In their PIR the provider gave an example of this and wrote, "We expect staff to report errors and challenge anything less than the values we expect to see on the understanding that we learn and improve from mistakes and also what is going well. Sharing compliments, good practice and new ideas is encouraged by discussions and reflection at team meetings and in supervisions." The PIR also provided information about other quality assurance systems such as, "By ensuring staff training is up to date" and "Acting on feedback from customers, families and commissioners. Compliments and complaints are shared, investigated and actioned accordingly."

People were empowered as they were provided with opportunities to share their views with the provider. In one person's survey we saw that they had made some less than positive comments. One team leader explained how this was managed and action was taken to improve the person's level of satisfaction. This included meeting with the person face-to-face and making changes to their planned care. Care plan reviews also fed into the provider's quality assurance system. Changes were made, if needed, to improve the quality of people's lives. This included, for example, promoting exercise and introducing effective weight-reducing programmes.

Staff were enabled to make suggestions to improve people's care during staff meetings and during their one-to-one supervision. One member of care staff gave an example of how their suggestion to purchase a swing, for people to use, was agreed by the management team. This was now awaited.

To ensure that people were in receipt of safe, quality care, the management team carried out both announced and unannounced 'spot checks'. These were to observe the quality and standard of members of

care staffs' work. Feedback was provided, if needed, to improve their working practices. One member of care staff said, "The 'spot checks' can be either announced or unannounced. We are observed as to how we communicate and how we are giving people choices. It's also ensuring that support [care] plans are being followed."

To ensure that people's care plans were accurate and complete the registered manager had completed a quality assurance audit of these within the last two months. One member of care staff said, "The support plans are kept up-to-date. There is a new audit form now being used."

The registered manager explained how information was obtained and analysed to ensure that people were receiving good, quality care. Information regarding complaints, safeguarding incidents, and accidents and incidents was sent to the provider. The registered manager told us that subsequently the provider would set any improvement actions that may be needed. These identified when the actions were to be taken and by whom. Subsequent quality assurance monitoring reports reviewed the actions and the completion of these.

Information held at the service, such as accidents and incidents, was compared to information we hold about the service. We found that there was no event that required the registered manager to submit required notifications to us. However, in the event of any authorised DoLS, we advised the registered manager that required notifications must be submitted to us.

The aim of people's support and care was to value their rights to make choices, decisions and independence. In addition to this, people were effectively supported to be integrated into the community. This was by taking part in work-related and recreational activities that were important to them.