Care Quality Commission

Dimensions (UK) Limited

Dimensions 27 Sampson Avenue

Inspection report

27 Sampson Avenue
Barnet
Hertfordshire
EN5 2RN

Tel: 02084490142
Website: www.dimensions-uk.org

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Dimensions 27 Sampson Avenue is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide accommodation and personal care for up to six people. There were five people using the service at the start of this inspection. The service specialises in the care and support of people with learning and physical disabilities. It is operated by a national care provider.

The service has a registered manager, which is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was an unannounced comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs, and well-led. It was the first time the service has been inspected under our ratings inspection process, having been dormant for a period until people moved into the service in the summer of 2017.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At this inspection we found the service was not consistently safe. Equipment and premises were not consistently checked to ensure environment safety risks were addressed. We had to remind the service that a professional check of the electric wiring was a few months out-of-date. Staff checks of some safety matters including wheelchairs, emergency lighting and first aid boxes had not recently occurred, and the last fire drill had not been documented.

Training on the prevention of choking was not complete for all permanent staff, despite some people using the service being identified as at risk of choking. Systems to check agency staff had received this training had not been followed.

We identified a few infection control risks during the inspection visit. Comprehensive infection control audits were not occurring, to help identify and eliminate poor practices.

We found the decoration of some communal areas of the building to be worn or incomplete. The dining room was not adapted for people in wheelchairs to use easily. The main fridge-freezer had been faulty for over six weeks without remedy.

The registered manager sent us updates and action plans on the above concerns shortly after our visit. This helped to reduce the seriousness of our findings.

There had been good work at the service this year to identify and meet some people's increasing care needs. There was effective co-operative working with community professionals in support of meeting people's health needs. Staffing levels had been increased where needed. Equipment such as more suitable wheelchairs had been acquired where appropriate.

Feedback from people, their relatives, visitors and community professionals was highly positive on how staff treated people. Staff interacted well with people regardless of some people's complex communication needs. There were established systems of providing people with personal care support where needed. People were encouraged to make choices where possible and their consent for care was sought in line with legislation.

People were treated as distinct individuals at the service, with care and support being offered accordingly. Staff supported people to follow their interests, have appropriate mental and physical stimulation, and maintain relationships that mattered to them.

The service supported people to eat and drink enough, maintain a balanced diet and be offered their medicines as prescribed.

Systems, processes and practices safeguarded people from abuse and made sure that ongoing learning took place when things went wrong.

The service promoted a positive and inclusive culture that achieved many good outcomes for people. Staff felt supported by the management team who displayed good competency and appropriate values for their roles.

The provider had a clear vision and credible strategy to deliver high-quality care and support. It engaged with and involved stakeholders in the development of the service. Systems at the service were designed to enable sustainability and support continuous learning and improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Equipment and premises were not consistently checked to ensure the environment was safe and infection control risks eliminated.

Training on the prevention of choking was not complete for all staff, despite some people using the service being identified as at risk of choking.

Systems, processes and practices safeguarded people from abuse.

The service ensured the proper and safe use of medicines.

The service ensured sufficient numbers of suitable staff to support people to stay safe and meet their needs.

Systems were in place to ensure that ongoing learning took place when things went wrong.

Is the service effective?

Good

The service was effective. People's needs were holistically assessed to help ensure the service was able to meet their specific needs.

The service made sure staff had the knowledge and experience to deliver effective care and support.

The service supported people to eat and drink enough and maintain a balanced diet.

The whole service worked in co-operation with other organisations to deliver effective care and support.

People were very well supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support.

Consent was obtained before support was provided. Where anyone could not make that decision, it was assessed in line with the Mental Capacity Act 2005.

The adaptation, design and decoration of premises was not consistently supporting people's individual needs to be met, but there were plans in place to address this.

Is the service caring?

Good

The service was caring. It ensured that people were treated with kindness, respect and compassion. People's privacy and dignity was respected at all times.

As far as possible, people were supported to express their views and be actively involved in making decisions about their care and support. Their independence was promoted.

The service supported people to develop and maintain relationships that mattered to them.

Is the service responsive?

Good

The service was responsive. It enabled people to receive personalised care that addressed their needs.

The service supported the communication needs of people with a disability or sensory impairment. It supported people to follow their interests and have appropriate mental and physical stimulation.

The service listened and responded to people's concerns and complaints.

Is the service well-led?

Good

The service was well-led. It promoted a positive and inclusive culture that achieved many good outcomes for people. Staff felt supported by the management team who displayed good competency and appropriate values for their roles.

The provider had a clear vision and credible strategy to deliver high-quality care and support. It engaged with and involved stakeholders in the development of the service.

Systems at the service were designed to enable sustainability and support continuous learning and improvement.

The service worked in partnership with other agencies to support care provision and development.

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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 3 August 2018, was unannounced, and was undertaken by one inspector and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

There were five people using the service at the time of our inspection visit. During the inspection, we talked with one person using the service, two of their relatives and representatives, and two visitors. We spoke with three support staff, the deputy manager and the registered manager. We also received feedback from two community professionals.

A number of people had complex communication needs who we could not understand well and gain views from. We therefore used other methods to help us understand their experiences. We spent time observing care and support in the communal areas such as the lounge and kitchen areas, and we looked around the

premises.

We reviewed care records of two people living at the service to see if they were up-to-date and reflective of the care which people received. We looked at two staff members' records, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rosters, agency staff records, and quality assurance processes, to see how the service was run. We then requested further specific information about the management of the service from the registered manager following our visit.

Requires Improvement

Is the service safe?

Our findings

People and their representatives felt the service to be safe. One representative told us their family member "is really safe in the home."

The service carried out risk assessments to help people take acceptable risks as safely as possible. This included for moving around the service, going out, use of equipment such as bed-rails and finances. There were health related risk assessments for areas such as nutrition and choking. The risks assessments were monitored, reviewed and adjusted as people's needs changed.

We identified that some people using the service were at risk of choking. This was evident from Speech and Language Therapist guidelines available in the kitchen for some people and from their care plans. One person's care plan made it clear that staff supporting them needed to have dysphagia training, to help staff understand the person's swallowing needs and recognise how to prevent choking risks. However, the management team told us two of the twelve permanent staff needed to complete this training. Additionally, agency staff profiles we saw did not state that they had been trained on dysphagia despite their training covering many other topics. The management team noted all staff had emergency first-aid training that covered choking scenarios; however, this would not ensure staff understood how to prevent choking from occurring. This was despite the provider considering choking to be a 'never event' in their Quality and Compliance reviews, something that is preventable but can have fatal outcomes if unaddressed. Following our visits, the registered manager informed us of actions to address these concerns.

The building had been adapted to promote safety. For example, there were window restrictors in use in upstairs rooms and many doors were fitted with devices to prevent anyone trapping their fingers between the door and the frame. Most equipment was regularly serviced and maintained, including the fire system, extinguishers and hoists for supporting people to move. However, the electrical wiring certificate was valid until April 2018. Arrangements were made for this to be re-inspected after we pointed out the concerns.

The last recorded fire drill in the service was a year old. The management team told us one took place around six months ago, but a record of this could not be found. A report of the drill was sent after the inspection visit along with that of a further drill that occurred after our visit.

Staff undertook monthly health and safety audits. The most recent one from July 2018 included for fire extinguisher checks to occur and highlighted that two hoists were in need of servicing. However, some safety checks were not kept consistently up-to-date. For example, monthly first-aid box checks for July had not yet occurred, and weekly wheelchair checks were last documented on 7 July 2018. The management team told us emergency lights were checked weekly as part of the general fire safety check records that we saw, but confirmed this had not been explicitly recorded recently. The last check we found was dated 1 May 2018. We also found a radiator cover in the hallway was not securely fastened.

The above information demonstrates that, without our intervention, the service was not ensuring routine staff safety checks were consistently occurring, to address risks to the safe care of people using the service.

Following our visits, the registered manager informed us of actions to address these matters.

Staff told us of good practical support for people's personal care, for example, that there was a good supply of personal protective equipment such as gloves and aprons, and that people received regular continence support where needed. Records showed good oversight that people received regular support to bath or shower.

The service had infection control and prevention systems, but these were not consistently followed in practice. Many areas of the service including the kitchen and people's rooms were clean and tidy. However, a waste bin in the kitchen needed to be opened by hand as the foot-pedal was not working. Defrosting meat was placed at the top of the fridge contrary to safe food hygiene principles. The lounge chair used by one person had dried food stains on the arm rest and seat. The management team confirmed there had been no infection control audits. This demonstrated failures to prevent, detect and control the risk of the spread of infection.

Following our visits, the registered manager informed us of actions to address these matters, including a new cleaning roster, a new kitchen bin, and further staff training.

The service ensured the proper and safe use of medicines. People and their representatives told us this was the case, for example, "I think her medicine is done in a timely manner." We saw that medicines were securely stored. Our checks of medicines stock, against records of medicines coming into the service and being administered, identified no discrepancies. The service's weekly stock checks of medicines supported this. There were also no gaps in the administration records. This indicated that people were supported to take their medicines as prescribed.

There was individualised guidance on how each person liked to have their medicines, for example, to give one person enough time to wake up before offering morning medicines. The record of the last annual pharmacist's audit identified good overall standards and only minor recommendations. Monthly staff meeting minutes showed regular updates on any changed medicines for people and findings from any medication checks undertaken.

The service ensured sufficient numbers of suitable staff to support people to stay safe and meet their needs. The management team told us there was always three staff working across the day, but a fourth worked six hours specifically funded for supporting one person whose needs had increased. Records of which staff worked confirmed these staffing levels were maintained in practice.

The management team told us of some staffing vacancies at the service. Records showed there were some long-standing relief and agency staff being used to help ensure consistent staffing who could respond to people's needs. Some of those staff were being permanently recruited as part of on-going recruitment in which applicants were selected based on matching the organisation's values.

The provider's online systems enabled us to see that Disclosure and Barring Scheme (DBS) checks were undertaken of staff working at the service along with entitlement to work in the UK. DBS disclosures are checks of police records and a list of people legally recorded as unsafe to provide care to adults. The registered manager told us written references were sought before employment offered, which a central recruitment team oversaw. We also saw profiles sent by agencies of the detailed recruitment checks they had completed for staff working in the service.

The service's systems, processes and practices safeguarded people from abuse. Risk assessments of

people's individual needs included consideration of whether they were at risk of abuse and what was in place or needed to be put in place to minimise the risk. Staff demonstrated a good understanding of the different types of abuse and the actions they would take to report any concerns, including where management on-call phones numbers were.

The service appropriately raised a safeguarding alert this year in respect of someone using the service being unable to access timely and robust health professional treatment following a fall and subsequent difficulties walking. This was in line with one of the provider's current objectives, of addressing health access inequalities. Another alert was made when one person was accidentally bruised as a result of another person's behaviour, to help ensure the needs of both people were met. An older alert had also been raised as a result of staff whistleblowing, which resulted in actions to prevent a reoccurrence of what was alleged to have happened. This all demonstrated that systems at the service were working to prevent abuse occurring.

The service learnt lessons and made improvements when things went wrong. Accident and incidents were recorded on the provider's computer system, to enable review of actions at different levels within the provider's management structure. Records showed they were discussed in staff meetings to ensure updates and concerns were shared with the staff team. Care plans and risk assessments were updated and amended if necessary.

Our discussions with the management team, and the previous registered manager in response to matters notified to us, showed that lessons were learnt and implemented. For example, in response to an accident, a number of environmental changes were made to reduce the risk of reoccurrence, along with referrals for additional community professional support. Duty of candour processes were followed in respect of liaison, explanation and apology to the person's representative.

Good

Is the service effective?

Our findings

People, their representatives, visitors and community professionals praised the capability of staff working at the service. Comments included, "It's a really good service, wonderful staff, very attentive to service users' needs", "The staff are really good" and "They are doing a good job and are a very caring team."

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. Whilst there was no-one newly using the service, staff and records informed us of some people's needs becoming more complex. A community professional told us of the service identifying and highlighting challenges to meeting these changing needs and working to address this with relevant community professionals. Another professional said the service considered how any new person moving into the service's vacant room would fit with people already there. The management team said they gained the support of specific community professionals to help make successful cases for additional staff funding where two people's needs had increased.

The whole service worked in co-operation with other organisations to deliver effective care and support. Community professionals told us this was the case, for example, praising the effective communication from the service to update them on changes to people's needs and abilities and on working in co-operation to better meet people's needs. We saw that people had hospital passports in place, to help inform hospital staff of relevant information about the person.

The management team told us of liaising with various community professionals in support of people's needs. For example, some people needed new wheelchairs and a shower chair, which was being arranged or had been acquired. Various health investigations and treatments had occurred for some people, to improve quality of life or attempt to halt increasing dependency. Staff feedback and records confirmed the service had prioritised joint working with community professionals in support of meeting people's needs especially around health concerns. For example, two people now had additional staffing due to their increased support needs following surgery.

The management team told us of following the STOMP initiative, national guidance on medicines reduction for people with a learning disability, which through consultation with prescribing professionals had benefitted some people using the service. Records confirmed this process.

The service supported people well to live healthier lives, have access to healthcare services and receive ongoing healthcare support. One person's representative told us of the service identifying that their family member was losing weight unplanned and acting accordingly in response to this. The management team showed us complements from various community healthcare professionals that praised the service's support of and commitment towards meeting people's healthcare needs.

Senior staff could explain each person's current health needs and what support was being provided, both in service and through liaison with community professionals. For example, one person had been supported to have treatment that meant they were now pain-free. They now slept better at night and were more content

during the day.

Staff knew what support people needed following health appointments. For example, one staff member told us of the healthcare support one person now needed before going to bed, following a recent hospital stay.

Staff praised the service for their consistent support systems for people's continence needs. One staff member told us it was the "first home I've come to where people can change regularly; (therefore) no skin problems." Health professional records showed the service had supported one person to heal a pressure ulcer acquired after hospital admission.

The service supported people to eat and drink enough and maintain a balanced diet. One person told us they liked the food. Another person's representative said, "I think she gets a balanced diet." There was also feedback that specific diets based on culture or religion were followed.

Staff knew people's needs and preferences around meals, for example, that one person was recently starting to refuse a certain cereal. People's preferences were also recorded in their care plans. Fresh fruit was available in the kitchen. A staff member emphasised that fruit and vegetables were regularly provided to people, as part of the twice-daily home-cooked meals.

Staff told us of providing people with frequent drinks and using fans to help people stay cool despite the warm temperatures around the time of our visit. They knew who did not like fans to be directed at them, and who needed more support to drink. They spoke of completing training on nutrition and hydration, and of promoting healthy foods and so, "Less oily or junk foods."

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 care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team informed us that applications had been made where appropriate and that assessors from the local authority were starting to visit in support of the process.

We were shown capacity assessments and best interest decision records for some people using the service in relation to some specific restrictive decisions. These included for moving to this service and for bed-rail use. The records showed consideration of the person's abilities and trying to support them to make decisions. Where appropriate, there was also consultation with other relevant people such as relatives and community professionals.

Staff told us of ensuring they gained consent as far as possible from people for providing care. For example, one person would sit up when ready for help to get up, but would lay down again if not consenting to support at that moment. Staff showed awareness of how different people communicated, in support of gaining consent.

The adaptation, design and decoration of premises generally supported people's individual needs to be met. The building was purpose-built several years ago, but had been vacant for a period until people moved

into it together from another service last summer. The provider's application to CQC at that time informed us of a newly-installed passenger lift and occupational therapist advice on the environment in terms of meeting people's needs. We saw the premises to have wide doorways and corridors, and moving and handling equipment that supported the needs of people living there who used wheelchairs.

However, we found the decoration of some areas to be worn or incomplete. For example, curtains were partially hanging loose off all three rails in the lounge. Corridors and some people's rooms had scratches and marks on the walls, and in some areas redecoration was incomplete such as behind pictures.

The dining room could not be used effectively as staff told us its table was too low for some people to sit at in their wheelchairs. A community professional pointed out the dining room was not big enough for everyone to use together and that there was not enough space to have a table in the kitchen. This was contrary to the provider's registration application for the service which informed us, "The people we support and staff eat together at the kitchen table which promotes a family atmosphere."

Staff told us the main kitchen fridge-freezer had been malfunctioning for the past two months but would be fixed soon. A smaller fridge-freezer was instead being used and so shopping was occurring more frequently due to the reduced space.

The garden was accessible and some people used it, but there was little there to stimulate or involve people as only basic maintenance of the garden was occurring. One wooden shed in the garden was rotting; the management team told us a replacement metal shed was being planned for. The registered manager told us of buying new furnishings and making arrangements for further redecoration. This was also evident in the service improvement plan supplied to us shortly after our visit.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. The registered manager told us new staff followed a documented induction process based on the needs of the service and people using it. Records showed this included agency staff, to help ensure they understood service requirements and people's needs. New employees shadowed more experienced staff as part of their induction for at least two weeks, to develop their knowledge of the service and people who lived there. In this time, they were also required to pass at 100% online training on core topics, along with some practical training such as for using hoists in the service. They then followed a national training program on essential care standards across a 12-week period.

We were shown the provider's online staff monitoring systems. It identified in advance any courses that any staff member was due a refresher training on, so helping to ensure staff stayed up-to-date on mandatory training courses.

Staff spoke of good support and supervision for their care roles. The registered manager told us staff received six developmental supervisions annually, one of which was an appraisal that involved asking the views of colleagues, people using the service and their representatives so as to provide a broad range of feedback. The service improvement plan showed that the management team were actively working to ensure staff were up-to-date with supervisions and appraisals. The registered manager also cited the provider's developmental program ('Aspire') that some staff accessed and which had led to greater engagement to the benefit of people using the service.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People and their representatives told us this was the case. Staff were described as "kind", "caring", "nice" and "respectful."

We heard frequent and friendly verbal interactions, such as, "Can you hold that for me, that is really helpful" and "Let's try and sit you up; that's better, you look more comfortable." Staff also provided people with physical reassurance such as a hand on the shoulder or a touch of the hand.

We saw that people were provided with support for their appearance where needed. For example, one person was well dressed for a trip out and had jewellery on. Staff supported people to put sun-cream on before going out as it was a very hot day. Staff also complemented people on their appearance, such as, "You look really lovely today; I don't think I have seen you wearing that necklace for a long time."

The provider had systems to make sure staff working in the service displayed appropriate values. The registered manager told us staff recruitment processes included potential employees meeting people using the service, to see how applicants interacted and to gain feedback from people. New staff then followed a values-based induction that included clear focus on caring attributes such as respect, involvement and equal opportunities.

The service ensured people's privacy and dignity was respected and promoted. Staff could describe how they upheld people's privacy and dignity, and that this was emphasised in their induction into the service. We saw staff upholding people's dignity. For example, a staff member placed a light blanket on the legs of one person who kept lifting their knees to their chest.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. The registered manager told us of ongoing exploration of how people made choices, but cited providing support for one person at lunch in which the person was making the decisions. We saw adapted plates and cups, and so one person was helped to drink for themselves when the correctly adapted cup was used. Their care plan emphasised that the person liked to be as independent as possible.

People's care plans advised staff on how to involve them in making day-to-day decisions about their care and support, for example, by providing visual choices of what clothes to wear. Plans also identified people's preferences and how they communicated.

The management team told us people were enabled where possible to have the staff of their choice working with them. For example, one person said who they wanted from those staff working. They chose different staff for help with getting up and later for attending an appointment. They also provided opinions on the approach of new agency staff, for example, on whether or not they were patient with them, which influenced whether or not to retain those staff.

The service supported people to develop and maintain relationships that mattered to them. People's care plans included sections on friends and family such as who was involved and how the service supported this. Other records and staff feedback showed that people were supported to stay in touch with friends and family. This included providing support for key family members to visit their relative in the service where needed.

The service liaised appropriately with people's representatives, who told us of being kept informed on their loved one if, for example, they were unwell or injured. One person's representative told us they were "fully informed of any medical issues that happen" and that this occurred promptly. A visitor told us that staff always supported people to be ready for them, and that they were informed in advance if the person they visited regularly was not available.

Good

Is the service responsive?

Our findings

The service enabled people to receive personalised care that was responsive to their needs. Staff and the management team knew people's needs and preferences, and treated them as individuals. This was enabled through the provider's values, because some staff had worked with people a long time, and through detailed induction processes for any new staff that included time spent getting to know each person.

People's care files included one-page profiles of their key needs and preferences, plus details of their life histories. This helped guide new staff on working with the person. There were up-to-date care plans on a range of support needs that reflected people as individuals, structured in the form of what worked and what did not for that person. The plans also guided on what a 'perfect week' was for the person and what 'future dreams' and goals the service was to support them with.

The service recorded a review of people's care and support at the end of each month. Those we checked indicated improvements in some people's quality of life, for example, through noting one person appeared more content and that less incidents were occurring, plus they were more capable of moving around the building. The reviews also showed the service responded to health matters such as unexpected weight gain by liaising with community healthcare professionals for advice.

The service supported the communication needs of people with a disability or sensory impairment, which helped to reduce feelings of frustration from not being understood. A visitor told us that staff "chat to the people even though they don't get a response and they always seem to understand noises that the people use." A community professional told us of some longstanding staff being familiar with people's various methods of communication and hence being able to meet their needs well.

People's care plans included a section on communication. Where people could not communicate verbally, there was guidance on what they did instead, for example, pushing something away if it was not wanted or pointing to what they wanted. It showed how people expressed if they were happy, unhappy or in pain. It also stated whether or not they used assisted communication methods such as pictures or objects of reference.

The registered manager told us most people vocalised if unhappy, and that staff were in tune with that. We saw this to be the case when one person was supported to get changed to alleviate their discomfort. We also saw dialogue taking place between a staff member and someone using the service on what was needed from the shops. The process indicated the person was understood.

The management team told us of trying different communication methods with people through the support of community professionals. These included pictures and objects of reference, but that these had generally been unsuccessful. They noted many people could not see well but tended to take off glasses supplied to them and hence relied more on verbal cues. However, we saw that some people wore glasses where they consented to this.

The service supported people to follow their interests. For example, staff told us of people sometimes attending hairdressers and getting manicures. People's appearances confirmed this sometimes occurred, and there was reference to these activities in those people's care plans as things they enjoyed doing. One staff member told us of people supporting people to listen to culturally-appropriate music of their choice. We heard this to be the case in one person's room. A community professional told us consideration was given to people's preferences when selecting television channels.

Staff meeting minutes showed a musician visited the service on occasions, and that plans were made to support people to go out to places they enjoyed, such as a local resource centre where people could use sensory-stimulation facilities.

One staff member said they were proud of supporting people's quality of life, for example, "We read to them, play games with them and see their happy faces." We later saw this staff member interacting with someone with high needs in a friendly and involving manner that the person responded to. We saw another staff member placing a small exercise ball in one person's hand for stimulation purposes, as the person had limited movement. The management team told us one person was supported to undertake online shopping. We saw one person have an art therapist visit.

The service listened and responded to people's concerns and complaints and used this to improve the quality of care. People's representatives told us the service responded to any concerns raise, for example, "I feel that the staff are approachable." A visitor told us they could raise any concerns with managers and that action would be taken. The management team told us there had been no formal complaints since the service began last year.

Good

Is the service well-led?

Our findings

The service's new manager had been in post for a few months at the time of our visit. They had successfully been registered with us for that role, indicating appropriate capability, qualifications and experience. The previous registered manager was now mentoring the new registered manager. A representative told us the outgoing manager "has been really good, shows a lot of responsibility." They added they had been kept informed of the change of manager.

The provider had a clear vision and credible strategy to deliver high-quality care and support. The long-standing deputy manager demonstrated clear communication skills and was very well informed about what was happening in the home regarding people and staff. They and the incoming registered manager also worked in an open and transparent manner with the inspection team throughout the inspection process.

The service promoted a positive and inclusive culture that achieved good outcomes for people. Staff told us of good support from the management team, that they "do listen to us." They also referenced good team work. One staff member told us, for example, "We talk to each other, 'can we try this?'; all give an opinion, but we come to one conclusion." Another explained support tasks were allocated during daily shift-planning, but, "If I'm free, I go and support" regardless of who was allocated. A third said, "Managers check everything. They're very approachable and helpful (but) they don't joke with clients' (welfare)."

Staff meetings were held in support of maintaining a positive and empowering culture. Monthly meeting records included consideration of the on-going support needs of people using the service, lessons learnt from any accidents and incidents, and planning ahead for any appointments anyone using the service had. This helped to show there were systems in place to enable good outcomes for people.

The provider engaged with and involved stakeholders in the development of the service. The management team told us of people and their representatives being invited to the provider's conferences and development days. We were shown the provider's overall survey results from the most recent quarter-year, by which ongoing monitoring of feedback on all services was acquired. This covered the views of people using the service, their representatives, community professionals and staff. This enabled recognition of strengths and areas for improvement across the provider's services as a whole.

The provider's governance framework was designed to ensure that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. For example, we were shown a summary of the latest report of the provider's quality auditing team from six months before our visit. It emphasised that key risks to people's safety were well managed, but identified some areas for improvement which had been actioned by the registered manager.

Systems at the service were designed to enable sustainability and support continuous learning and improvement. The registered manager sent us an updated service improvement plan shortly after our visit. It included a plan to address all agreed concerns identified at the inspection visit, along with some other matters already identified by the management team and provider such as recruitment of permanent staff.

The plan also evidenced some completed matters such as disposing of items temporarily stored in the garden and ensuring shift-leader responsibilities were completed.

The management team explained and showed us the provider's plans to support people better with planning, developing and achieving specific goals. This 'Activate' program had been explained to staff at a recent meeting, but further support was to be given to help start the process in practice and ensure its success.

The service worked in partnership with other agencies to support care provision and development. The management team told us of working with local professionals, for example, acquiring training from incontinence product supplier at which they were encouraged to invite other involved community professionals for the overall benefit of people using the products.