Dimensions (UK) Limited

Dimensions 6 Queens View Crescent

Inspection report

6 Queens View Crescent
Scunthorpe
South Humberside
DN16 1QN
Tel: 01724 270407
Website: www.dimensions-uk.org

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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

Overall summary

This unannounced inspection took place on 29 May 2015. At the last inspection on16 June 2013, the registered provider was compliant with all the regulations we assessed.

Dimensions 6 Queens View Crescent is a purpose built single storey home for up to six people with a learning disability. It is situated in a residential setting and close to local facilities. The home has six single bedrooms, a bathroom, a kitchen, a laundry and a large lounge/dining room. There is a garden at the rear of the property and car parking at the front. At the time of the inspection there were six people living in the home.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found staff were recruited in a safe way; all checks were in place before they started work and they received an induction. Staff received training and support to equip them with the skills and knowledge required to support the people who used the service. There were sufficient staff on duty to meet people's health and welfare needs.

We found there were systems in place to protect people from the risk of harm and abuse. Staff had received training and knew how to report any concerns. They had policies and procedures to guide them.

We found people's health and nutritional needs were met and they had access to a range of professionals in the community for advice, treatment and support. We saw staff monitored people's health and responded quickly to any concerns. There had been some errors regarding medicines administration since the last inspection but we found improvements had been made in the way staff managed medicines. This ensured people received their medicines as prescribed which helped to maintain their health.

We saw people had assessments of their needs and care was planned and delivered in a person-centred way. Risk assessments had been completed to provide staff with guidance in how to minimise risk without this impinging too much on people's independence. People had access to activities within the service and community facilities.

We observed staff treated people with dignity and respect and it was clear they knew people's needs well. Staff helped people to make their own choices and decisions. When people were assessed as lacking capacity, staff followed the principles of the Mental Capacity Act 2005 and held best interest meetings, with relevant people present, to make decisions on their behalf.

We found the environment was accessible and safe for people. Equipment used in the home was serviced and an issue of overloaded extension leads was addressed on the day of inspection.

There was a system of audits and checks to look for shortfalls and to rectify them so the quality of care could be improved. This had proved effective, for example in the management of medicines. Relatives and staff told us they felt able to express their views about the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were systems in place to safeguard people from the risk of harm and abuse. Staff knew how to recognise abuse and what action to take if they had any concerns.

Risk assessments were completed and the environment made safe for people.

Staff were recruited in a safe way and there were sufficient staff on duty to meet people's needs.

People who used the service received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

People's health and nutritional needs were met. They had access to health care professionals when required and in a timely way.

People were supported to make their own decisions and when assessed as lacking capacity to do this, the registered manager acted within the law to ensure their rights were upheld.

Staff received training, support and supervision in order for them to feel confident when supporting people who used the service.

Good

Is the service caring?
The service was caring.

Staff were observed as caring and considerate when supporting people who used the service.

People were treated with dignity and respect and provided with information and explanations prior to and during care support tasks.

Good

Is the service responsive?
The service was responsive.

People who used the service received care and support that was person-centred and met their individual needs.

People were supported to access community facilities and were encouraged to participate in meaningful occupations within the service.

There was a complaints procedure in easy read format to help accessibility for people who used the service. Relatives told us they would feel able to raise concerns and staff knew how to deal with them.

Good

Is the service well-led?
The service was well-led.

There was an open-door culture within the service and the organisation, which enabled people to raise concerns.

Good

Summary of findings

The registered manager involved a performance coach when they had recognised the need to team build and improve communication.

There was a quality monitoring system that helped to identify shortfalls so they could be addressed. An alternative means of seeking the views of people who used the service was under development, as the registered manager had recognised the current system had not been wholly effective.

Dimensions 6 Queens View Crescent

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.

The inspection took place on 29 May 2015 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection we spoke with the local authority contracts and performance team about their views of the service and received a report they completed of their last visit to the service.

During the inspection we observed how staff interacted with people who used the service. We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the relatives of four people who used the service. We spoke with the registered manager and three support workers. We spoke with a speech and language therapist following the inspection.

We looked care files of two people who used the service. We also looked at other important documentation relating to the six people who used the service such as their medication administration records [MARs] and accident reports. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf. We also checked to make sure the registered provider acted within the law when people who lacked capacity were deprived of their liberty.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, supervision and training records, the staff rota, menus, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records.

Good

Is the service safe?

Our findings

Relatives told us they thought people who used the service were well cared for and safe within the home. Comments included, "They do really well and look after her well", "I'm happy and all the family are happy with the care", "Yes, he is safe; they do have a lock on the door so he can't get out onto the road" and "Yes, she is safe there; she is unsteady and having a few falls but they are trying their best to resolve it."

Relatives also told us the service was clean and tidy. They said, "It's always been clean and tidy when I've gone" and "I've never seen it looking anything other than good." One relative told us that although the service was clean, they thought the decoration was looking a bit jaded in parts.

We had discussions with staff about how they safeguarded people from the risk of abuse and harm. Staff confirmed they had received safeguarding training and in discussions, they were able to describe the different types of abuse and the action to take to report concerns. The registered manager had received safeguarding training and we saw they had followed policies and procedures when reporting incidents to the local authority safeguarding team. We found that when the local authority safeguarding team asked the registered manager to check out incidents of concern, these were completed appropriately and in a timely way.

We saw risk assessments were completed to support people who used the service to minimise risks whilst helping them to remain as independent as possible. Staff could describe the risk assessments and the measures in place to guide them when supporting people. They told us they had time to read care files and changes in information were passed on to them in handovers. It was important for staff to have up to date information about people's needs to ensure their safety and welfare. The risk assessments covered areas such as moving and handling, epilepsy management, choking when eating or drinking, the use of bed rails, activities within the service and accessing community facilities such as swimming.

We checked recruitment records of two staff newly appointed to work in the service. We saw gaps on application forms were explored, references obtained and disclosure and barring checks made prior to their first day of employment in the service. These checks helped to ensure only appropriate people were employed to work with adults who could be vulnerable to the risk of abuse and harm. One new member of staff confirmed the recruitment process and told us they had an interview to assess their fitness and completed an induction. They said this included a probationary period of six months, meetings to check progress, specific training, reading care files and policies and procedures, shadowing more experienced staff and observations of their practice.

Discussions with staff, a check of the staffing rota and observations of practice indicated there were sufficient staff employed to meet the needs of people who used the service. The numbers of staff on duty each day fluctuated in line with activities people completed and one to one support they received. There was one member of staff on duty at night and an additional member of staff who completed a sleep-in duty at one of the registered provider's other units nearby. This member of staff was available to support any of the three units at night as required. Staff said, "There's time to spend one to one with people; it would be nice to spend more time with people though."

We found people received their medicines as prescribed. Medicines were obtained, stored, administered and recorded in line with good practice. There were protocols to guide staff when people were administered medicines, 'when required'. These indicated what the medicine was for and the maximum dose. There was guidance for staff when supporting people with epilepsy rescue medicine. These described the presentation of the seizure, when to administer the medicine and what to do if it was not effective. There was also information about each medicine, letters containing instructions from GPs and stock control checks. There had been six minor medication administration errors between October 2013 and December 2014. The registered manager had highlighted these during audits of medicines and the people who used the service had not experienced any ill-effects. An action plan had been formulated which consisted of re-training, supervision sessions and observations of practice for staff. This had been effective and there had not been any further medicines errors.

We saw the environment was safe for people who used the service. Equipment used there was maintained and serviced in line with manufacturer's instructions. All people who used the service had evacuation plans to guide staff

Good

Is the service safe?

and emergency services in how to move and handle people safely and quickly when required. Staff had completed first aid training and there was a first aid kit in the service. The close proximity of the registered provider's other services meant these could provide temporary support in emergency situations. We noted some overloading of extension leads in some people's bedrooms due to the amount of sockets required for their electrical appliances.

The registered manager discussed this with the registered provider's health and safety officer during the inspection and plans were made to address this by installing more sockets in the bedrooms that required them.

We saw the service was clean and tidy. There were some minor infection prevention and control measures to undertake to improve the service. The registered manager told us they would address these quickly.

Good

Is the service effective?

Our findings

Relatives told us they thought people's health needs were maintained and that staff were skilled in looking after them. They also told us they had, on occasions, observed the meals people had and felt these were appropriate. Comments included, "Yes, they do get their GP out quickly when necessary", "He has all his food mashed up now; they know what they have to do", "The food is great; I've seen it and they do it well and it's been nice" and "The staff seem to be very good." One relative said "They do look after her health; she is losing weight but the dietician is involved and I'm not concerned." We observed this person was given second helpings at breakfast. One relative said there had been changes to the staff team recently and they felt the newer staff didn't know their family member's needs as much as the other staff. They said, "I think they could encourage her to eat more when she says she doesn't want it."

A speech and language therapist who visited the service to provide guidance to staff said, "I spoke with a number of staff and they were knowledgeable about his eating and drinking needs. I observed mealtimes and it was positive; they followed guidelines and asked questions if they were not sure of anything" and "I saw them offer choice at mealtimes."

We saw people's nutritional needs were assessed and kept under review. There was information in the kitchen to guide staff when preparing meals for people with specific needs such as swallowing difficulties. There was equipment such as adapted cutlery, plate guards and specialist cups to assist people when eating and drinking. Staff prepared menus for the week for breakfast, lunch and the main meal in the evening but they told us these were subject to change if people who used the service wanted something else. We saw there was a range of food and drink supplies in the service.

Observations showed people chose to eat their meals in different places. Some people used the dining table and other used the table in the kitchen. Staff recorded the meals and fluids each person consumed each day and commented on whether they liked particular foods or disliked others so a preference list could be maintained. In one of the care files we looked at, the person had been prescribed food supplements by a dietician; these were recorded accurately on the medication administration record as provided to the person twice a day. We saw people had their weight monitored and appropriate action taken when there were concerns.

We saw the health care needs of people who used the service were met. They had been referred to health professionals for assessment, treatment and advice when required. These included, GPs, dieticians, speech and language therapists, emergency care practitioners, specialist nurses for epilepsy management, podiatrists, dentists, and opticians. Records indicated people saw consultants via out patient's appointments, accompanied by staff, and had annual health checks. We saw each person had a health action plan which detailed their health care needs and who would be involved in meeting them. This helped to provide staff with guidance, information about timings for appointments and instructions from professionals.

In discussions it was clear staff knew people's health care needs and they described the professionals involved in their care. Comments included, "We have health action plans and yearly updates", "The service users have annual general health check-ups", "We understand people's needs well" and "They go out to the opticians and dentists."

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities in relation to DoLS and had made applications to the local authority but these had not been finalised and authorised as yet.

Staff had received training in the Mental Capacity Act 2005 [MCA] and they were clear about how they gained consent to care and support prior to carrying out tasks with people who used the service. Staff said, "We have to use body language. If they don't want to do things they will let us know; just because they can't talk doesn't mean they can't communicate", "We ask people. Some service users can't say, so we go by facial expressions and body language; we can't force people to do things and if they refuse, it's their decision" and "If a service user doesn't want to get up I would support them, sit and talk to them explain why it's necessary and give reasons. I could ask another colleague to assist as sometimes a change of face makes a

Good

Is the service effective?

difference." There were records of assessments under MCA and best interest meetings had been held when people were assessed as lacking capacity to make important decisions. A relative confirmed they were involved when decisions were required about a person's expenditure.

We saw staff had access to a range of training relevant to their roles to help them to feel confident when supporting people who used the service. This included training considered essential by the registered provider such as safeguarding, fire safety, first aid, basic food hygiene, moving and handling, equality and diversity, data protection, person-centred care, safe handling of medicines and infection control. Other training included epilepsy management, autism, dysphagia and dementia awareness sessions, communication methods and MCA/ DoLS. Training consisted of e-learning, practical instruction and face to face training. The training records were held electronically and there was a system to alert the registered manager when refresher courses were due. Records indicated some staff had completed, and others were registered to start, a nationally recognised qualification in health and social care.

Staff told us they felt supported by management and had regular supervision meetings and annual appraisals. Staff records confirmed supervision meetings included discussions about training, what was working well for the member of staff and any issues relating to people who used the service. There was a scoring system to gauge whether staff were meeting expectations and what areas they could improve on.

The environment was purpose built and single storey to help best meet people's mobility needs. Certain adaptations had been made such as grab rails, ramps, a low work surface in the kitchen, and moving and handling equipment was available.

Good

Is the service caring?

Our findings

Relatives told us staff were caring and friendly. Comments included, "The staff are marvellous; it's not just a face they put on for the public, they really are good", "They keep in touch and let me know when he's unwell", "I would rate it as good; I don't think they could make any improvements", "There have been some changes but the staff seem very good" and "Staff changes have been upsetting; I get on with long-standing staff and her key worker is brilliant."

A speech and language therapist told us, "Staff are friendly and provide a good service." A social worker said, "Staff have appeared to treat service users with dignity and I have had positive feedback from families."

We observed staff interactions in the kitchen and dining room/lounge all morning. These were positive with staff speaking to people in a caring way. It was clear some staff had developed strong relationships with the people they supported; when individual staff approached them, their energy levels lifted and they were clearly happy to see the member of staff. This was observed through their body language of smiles, gestures and touches. Staff were seen to approach people sitting in chairs at an appropriate level and distance, they were observed providing explanations to them about activities/outings to be undertaken and they were seen placing their hand over a person's hand to guide them in a task. We did note there were some missed opportunities for staff interaction with specific people, when staff moved in and out of communal areas, but on the whole we judged the interactions to be good.

We observed staff providing a visual choice for lunch by showing people two items. One of the items was a tinned product, which staff told us would have been used for sandwiches or on toast. A picture of a sandwich or an item on toast would have provided people with a better idea of the finished meal. There was a magnetic notice board in the dining area which had some pictorial information and pictures of meals on it but this needed tidying up to make it up to date. The registered manager told us there was a catalogue of pictorial menus for staff to use when checking what people wanted for each meal and they would ensure this was used consistently.

We saw people were treated with dignity and respect. Doors were closed during personal care tasks, people were provided with clothes protectors at mealtimes as required and they wore clothing of their choice. Staff described how they promoted core values such as choice, privacy and dignity. Comments included, "We always knock on doors and treat people with respect, as you would want to be treated", "We close doors and curtains during personal care" and "We encourage them to do things for themselves." Staff described the support each person required and how they helped them to remain as independent as possible with aspects of their lives. One member of staff said, "We need to put X's socks on and lay clothes out but then they get dressed" and "X needs full support but we can put our hand over theirs to guide it when supporting them to wash in the bath."

The registered manager told us they had completed a 'matching support' exercise; this identified the skills and interests people who used the service would ideally like in their key worker. This helped people and key workers to form relationships based initially on common interests. The registered manager described how people who used the service were involved in the recruitment of staff. This involved the registered manager and senior staff observing how candidates interacted with people who used the service during their interview day when they were introduced to them.

Each person had their own bedroom, which afforded them privacy and space when they wanted to be alone. The bedrooms were personalised and decorated with pictures and items of their choice and interest. For example, one person was a keen football fan and posters of their favourite side were on the walls.

We saw there were specific policies, procedures and records in an easy read format such as the complaints procedure and review of care plan documentation. In each care file there was also easy read information titled, 'Disability Hate Crime' produced by the Crown Prosecution Service. This provided guidance to people who used the service about their human rights. The easy read documents helped to provide people with information in a format which was easier to understand.

Care plans included preferences for how people wanted care to be delivered to them. This was demonstrated in "Getting to know me" information. The information was gathered from talking to people who used the service, watching how they responded to questions, gauging their reactions to activities and studying preferred routines. It also involved gathering life histories by talking to relatives

Good

Is the service caring?

and health and social care professionals involved in people's care and support. The registered manager described how one person had been involved in making decisions about their holiday. An advocate and a relative had been involved to support the decision-making and the person was involved by showing them photographs and watching their facial expressions. This showed us that people were helped to be involved in decisions about their care.

We saw advocacy services were used to support people when required.

We saw there were policies on data protection and confidentiality. Staff signed to say they had read and understood these policies. This meant staff were provided with guidance on how to protect confidential information. Staff used an office to hold telephone conversations or meetings with people in private to ensure these were not overheard. Care files were stored in a cupboard and staff personnel files were held securely. We saw computers were password protected to help safeguard personal information.

Good

Is the service responsive?

Our findings

Relatives told us people were treated as individuals and they were aware of some of the activities and community facilities they accessed. They said they knew how to make a formal complaint and would feel able to raise concerns knowing they would be sorted out. Comments included, "They bring him to see me", "They do all they can do; he goes on holidays, to shows, swimming, walking and plays drums", "Yes, I would see whoever is running the bungalow [to complain]", "Yes, I would complain but I've never had to" and "I complained once and wrote to head office as it wasn't sorted to my satisfaction."

One relative told us they thought their family member had not accessed swimming sessions as often as had been planned. We spoke with the registered manager about this and they confirmed there had been disruption to some people's routines due to staff changes and training of new staff. This was also confirmed in information from a social worker involved in supporting one person who used the service. The changes had meant the access to community facilities had been more ad hoc than structured. However, this had now improved and rotas for the next month meant people's routines could be planned in a more effective way.

A speech and language therapist told us staff had been responsive to people's changing needs. They said, "They liaised about the right cutlery for him" and "I suggested a spouted beaker for another person and they actioned this very quickly."

We saw care was delivered in a person-centred way. Each person had care files that provided staff with personalised information. This included completed documentation titled, "What is important to me", "How to support me well", "What I can do independently", "What works and what doesn't" and "What I need you to do for me." There were records of routines, personal histories, family and friend connections, birthdays of relatives and one page profiles to give staff a quick summary of the person's main needs. We saw the information in care plans was detailed and provided staff with guidance. For example, one care plan we saw had two pages dedicated to how the person communicated their needs. They included what specific facial expressions meant, what the meaning was behind gestures and what action staff needed to take. Another person had very detailed information about their nutritional intake and the required texture of their food to prevent them from choking.

We saw each person had an information sheet held with their medication administration record. This detailed in a person-centred way how they preferred to take their medicine. For example, one stated, "Offer on a spoon with a little bit of yoghurt informing me what you are doing".

We observed staff followed the person-centred care plans in practice during their support of people at mealtimes and when they were communicating with them.

We saw care plans were evaluated and reviewed monthly and included information about what had been tried, what had gone well or raised concerns, what they had learned during the month and what the next plans were.

Staff completed daily recording and monitoring in monthly books printed for this purpose, which prompted them to include specific information. We saw this included what people had eaten for their meals, what their general health was like, how they had spent their day, what contact there had been with family and friends, what activities they had completed and any community facility they had accessed. Staff also recorded any marks on a body map and monitored people's weight and their bowel function to alert them to concerns which might need speedy action.

People had activity plans regarding access to community facilities. Some people were funded to have additional staff hours for this. For example, during the inspection one person went out for several hours on a one to one basis with staff. Records showed the community facilities accessed included a bird sanctuary, a local social club, a music group, swimming, a walking group, bowling, drum practice, garden centres, pubs, shops and cafes. One person was a season ticket holder for their football club and attended matches. There were also activities and meaningful occupations completed in-house. These included, baking, helping to prepare meals, assisting with personal laundry, arts and crafts, games, using the sensory equipment, hand and foot massage, nail care, watching television/DVD's and listening to music. Staff told us one person liked to do exercises. Holidays were planned each year for people. The registered manager told us a specific budget was allocated to pay for staff when accompanying people who used the service on holiday.

Good

Is the service responsive?

There was a complaints policy and procedure and staff were familiar with the actions to take if they received a complaint or concern. The policy and procedure was in easy read format to help the people who used the service to understand the contents. In discussions staff told us they received very few complaints. The registered manager said, "The reality is the people we support are not able to make formal complaints so we have to be aware of body language to see when they are unhappy with something." They told us any complaints received were recorded on the computer and there were specific letters to send to people to acknowledge the complaint and keep them informed of any investigation and outcome.

Good

Is the service well-led?

Our findings

Relatives spoken with knew the registered manager's name and told us they were able to express their views either when they visited, at formal reviews, during telephone conversations or in surveys. Comments from relatives were, "The manager is brilliant", "Yes, I get sent a survey and it gets filled in eventually", "I can't always get to reviews but they let me know", "I'm invited to meetings", "I'm included in discussions" and "There are reviews and they send me minutes."

A social worker told us they had spoken with the registered manager about terminology on some paperwork used by the organisation. This referred to people who used the service having tenancy agreements and paying 'rent' when their care was funded by the local authority. There was no question that the people who used the service were charged an extra amount but the wording was confusing. The registered manager told us they had directed the local authority to discuss this with the registered provider's housing officer.

There was a clear hierarchy within the organisation, overseen by a Board of Governors, which consisted of a Chief Executive Officer, Directors, Regional Managers, Locality Managers, Assistant Locality Managers and Support Workers. The Locality Manager was also the registered manager for 6 Queens View Crescent and two other services in close proximity.

We spoke with the registered manager about the culture of the organisation and their management style. They said, "We have an open culture where we seek staff views and they can put them across", "I try to be enabling; I do all the appraisals so I can sit down with staff in a focussed way" and "I have three services to manage so I try to move around them all to see the service users and the staff." The registered manager described how there had been communication issues, staff changes and dynamics that required attention to ensure the team worked well together. They had involved the registered provider's performance coach to assist in the development of the team, which they felt had been successful. The performance coach had recently spent a day with staff, observed their practice and was available for them to speak to on an individual basis. A verbal discussion had taken place with the performance coach about their findings and staff had been involved in discussions about how they could improve communication. The registered manager told us they were waiting for further results from the performance coach so an action plan could be developed; this was to include how engagement with people who used the service could be enhanced further.

We found the organisation encouraged good practice. For example, there was a system in the organisation to nominate staff for specific awards for recognition of good practice. The organisation also had 'Investors in People', which was an accreditation scheme that focussed on the registered provider's commitment to good business and people management. Staff were provided with handbooks which explained what the expectations were of their practice. It also described the organisation's vision. This was described as promoting an 'inclusive society where people have equal chances to live the life they choose'. The mission was to 'make a difference to people by delivering personalised support that improves the quality of life'. Staff received remuneration for long service within the organisation and there were incentives such as an on-line discount scheme and 'recommend a friend'. This provided staff with a reward if the friend was successfully recruited to work within the organisation. The registered manager also described an employee assistance programme which consisted of financial advice and counselling.

We found the registered manager was aware of their role and responsibilities and notified the Care Quality Commission, and other agencies, of incidents which affected the welfare of people who used the service. Our records showed us notifications had been received regarding medication errors which had occurred between a set period of time. They indicated what action had been taken and how staff practice was to be monitored. There have been no further medication errors which showed us good practice had been embedded in medicines management. We have found the registered manager responds to requests for information when required.

The service had access to vehicles which could be used to support people to attend local facilities. We had previously raised concerns that the use of the vehicles was not spread thoughout the three services in an equitable way, as although each person paid the same amount each month, some used them more frequently than others. We asked the registered manager to audit this system and we received the outcome which confirmed it was inequitable.

Good

Is the service well-led?

The registered manager told us they had gathered information about alternatives to this system and over the next two weeks, it was to be discussed in best interest meetings with the local authority and relatives.

There was a corporate quality monitoring system in place and records were held on the computer. This meant the quality assurance team within the organisation could access and analyse information inputted by the registered manager and discuss with them what action had been taken. For example, we saw accident monitoring for one person had been completed. This had triggered the quality assurance team to follow up with the registered manager what action had been taken to ensure the person had been referred to the local falls team. We saw a general compliance audit had been completed by the quality assurance team over two days in October 2014. This included how people who used the service were involved in their care, an observation of staff support and engagement, management processes such as recruitment, supervision and training, a check of how finances and medicines were managed, an examination of records and a report of health and safety issues. We saw the audit picked up shortfalls, gave the service a compliance score and resulted in an action plan with timescales for the staff to complete. The registered manager told us the quality assurance audit was discussed in their own supervision if required so that progress could be monitored.

We saw there were audits and checks completed in the service. These included checks of, for example, the environment, hand hygiene, skin tears people who used the service may acquire, bathing temperatures, finances, a stock check of medicines and administration records and hot water outlets. Any shortfalls picked up were addressed via action plans.

We saw staff were able to express their views in team meetings, supervision sessions, appraisals and on a day to day basis. Staff told us, “It’s a good environment here; the manager is available for support and advice when needed”, “There is an open-door policy more or less”, “I do like working here” and “We have a good team here and the service users seem happy with the care.” There were various methods of ensuring information was passed on to and between staff. These included handovers at each shift, a communication book, briefings, newsletters, team meetings and via emails. The registered manager told us all staff had access to a portal on the computerised IT system; this enabled them to access policies and procedures and to record their training information.

The registered manager told us the meetings for people who used the service had not been very successful and they were looking at alternative ways of gaining their views about the service and recording them. The views of relatives were sought on a day to day basis or during care plan reviews.