Royal Mencap Society

Mencap - Gateshead and Durham Domiciliary Care Agency

Inspection report

20-21 Marquis Court
Tenth Avenue, Team Valley Trading Estate
Gateshead
Tyne and Wear
NE11 0RU

Website: www.mencap.org.uk

Date of inspection visit:
28 June 2016
07 July 2016
18 August 2016

Date of publication:
10 October 2016

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

This was an unannounced inspection carried out over three days on 28 June, 7 July and 18 August 2016.

We last inspected Mencap Gateshead and Durham in March 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Mencap Gateshead and Durham domiciliary care agency is registered to provide personal care to adults with learning disabilities. People are supported by staff to live individually in their own homes or in small groups, referred to as independent supported living schemes. Different levels of support are provided over the 24 hour period dependent upon people's requirements. Many of the people are tenants of their home and pay rent for their accommodation which is leased from housing associations.

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

People told us they felt safe. Robust vetting procedures were in place when new staff were recruited. People were relaxed and appeared comfortable with the staff who supported them. Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions for themselves. There were other opportunities for staff to receive training to meet people's care needs.

Staff knew the people they were supporting well. Care was provided with patience and kindness and people's privacy and dignity were respected. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care. People were supported to maintain some control in their lives. They were given information in a format that helped them to understand if they did not read to encourage their involvement in every day decision making.

People told us they were supported to go on holiday and to be part of the local community. They were provided with opportunities to follow their interests and hobbies and they were introduced to new activities. People had food and drink to meet their needs. Some people were assisted by staff to cook their own food. Other people received meals that had been cooked by staff. People had access to health care professionals to make sure they received appropriate care and treatment. People received their medicines in a safe and timely way. The premises were clean with a good standard of hygiene but we have made a recommendation about referring to guidance in relation to infection control.

People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Appropriate checks were carried out before staff began work with people. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

We have made a recommendation about infection control.

Is the service effective?

Good

The service was effective.

Staff had a good understanding and knowledge of people's care and support needs.

People's rights were protected because there was evidence of best interest decision making when decisions were made on behalf of people. This occurred when people were unable to give their consent to their care and treatment

.
People received food and drink to meet their needs.

People received appropriate health and social care as other professionals were involved to assist staff to make sure people's care and treatment needs were met.

Is the service caring?

Good

The service was caring.

Relatives and people we spoke with said staff were kind and caring and they were very complimentary about the care and support staff provided.

People were offered choice and staff encouraged them to be

involved in decision making whatever the level of support required.

People's rights to privacy and dignity were respected and staff were patient and interacted well with people.

Is the service responsive?

Good

The service was responsive.

People received support in the way they wanted and needed because staff had guidance about how to deliver people's care.

People were supported to live a fulfilled life, to contribute and be part of the local community. They were encouraged to take part in new activities and widen their hobbies and interests.

People told us they knew how to complain if they needed to. They had a copy of the complaints procedure and it was written in a way to help them understand if they did not read.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place who promoted the rights of people with a learning disability to live a fulfilled life within the community.

An ethos of involvement was encouraged amongst staff and people who used the service. Staff and people who used the service said communication was effective.

The registered manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

Mencap - Gateshead and Durham Domiciliary Care Agency

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.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams.

This inspection took place on 28 June, 7 July and 18 August 2016 and was an unannounced inspection. It was carried out by an adult social care inspector. During the inspection the inspector visited the provider's head office to look at records and speak with staff. After the inspection the inspector visited two houses to speak with people who lived there and the staff who supported them.

As part of the inspection we spoke with seven people who were supported by Mencap staff, five support workers, the registered manager and nine relatives. We reviewed a range of records about people's care and checked to see how the schemes were managed. We looked at care plans for five people, four medicine records, the recruitment, training and induction records for five staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits that the registered

manager completed.

Good

Is the service safe?

Our findings

People told us they felt safe with staff. Their comments included, "I feel safe living here," "I'd go to the staff if I was worried, have a chat with them and they could sort it out," and, "If I had a problem I'd tell staff." Relatives' comments included, "[Name] is definitely safe there…they (staff) know [Name] very well," "We have no problems, [Name] is safe," [Name] tends to fall a lot but staff look after them very well," and, "[Name] is very happy and would definitely tell me if they were unhappy."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found 17 concerns had been logged appropriately since the last inspection. Safeguarding alerts had been raised by the service with the relevant local authority and investigated and resolved to ensure people were protected. The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities or independent investigations were carried out. Where incidents had been investigated and resolved internally information had been shared with other agencies for example, the local authority and the CQC.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. Records showed and staff confirmed they had completed safeguarding adults training. Staff members' comments included, "I've done local authority safeguarding training," and, "I'd tell the senior if I had a concern."

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. These included environmental risks and any risks due to the health and support needs of the person such as moving and assisting, epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. For example, risk assessments and corresponding care plans were in place for some people who had been assessed to be able to spend some time in the house on their own without staff support. Our discussions with staff confirmed that guidance had been followed.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we were told by the registered manager that the number of staff supporting a person could be increased or decreased as required after negotiation with commissioners of the service. As the service supported people to learn new skills and become more independent in activities of daily living a person might over time require less staff support. When a person became more dependent we were told by the registered manager the staff hours allocated to them had increased. We were told staffing levels were also adjusted and planned in advance to roster more staff on duty when people were going out to individual

activities.

Overnight one staff member was available who slept on the premises. People also had access to a care call system operated by the local authority if they were assessed as being at risk during the night. For example, records for one person who suffered seizures and was at risk of falling showed the 'Care Call' alert system had phoned the home to alert the staff member on duty the person was out of bed and required assistance. People and staff had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. A staff member commented, "There's an on-call number in the staff sleep-in room, I've rung the on-call senior when the fire alarm kept going off."

A personal emergency evacuation plan (PEEP) giving guidance if the house needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed six monthly to ensure they were up to date.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the senior in the house so that appropriate action could be taken. We were told all incidents were audited in each house and at head office to check action was taken as required to help protect people. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, if a person was at risk of falling. Systems were in place to ensure a safe environment for people. Records showed weekly health and safety checks took place around the house. One person told us, "We talk about keeping the house safe at our meetings." Records showed people took part in fire drills so they knew what to do in case of fire.

We checked the management of medicines. People received their medicines in a safe way. Medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. The registered manager told us any reported medicine errors were reviewed and action was taken to strengthen and help protect people with regard to medicines management.

We observed there was a good standard of hygiene around the premises. However, we saw there was a communal hand towel in use by the hand wash basin in the communal lavatory. We were aware it was the tenant's own household but we had concerns about the risk of cross infection as more than one person dried their hands on the towel. We discussed this with the registered manager who said it would be addressed.

We recommend that the registered manager consults, "The Health and Social Care Act 2008 Code of Practice" on the prevention and control of infections and related guidance ('the Code')

Staff we spoke with and staff records confirmed staff had been recruited correctly. The necessary checks to ensure people's safety had been carried out before people began work in the service. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included, "We get a lot of training," "I've first aid training on the 30 August," "We get plenty of training," and, "My training is on-going." Relative's comments included, "Staff are well trained and competent," "They do a great job," and, "Staff are excellent."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. A staff member commented, "I was nervous when I first started but I shadowed a member of staff and got to know the job." This ensured they had the basic knowledge needed to begin work. The registered manager told us new staff completed a twelve week induction and studied for the Care Certificate in health and social care as part of their induction training. The PIR showed existing staff members also studied for the Care Certificate.

The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as autism, epilepsy awareness, acquired brain injury, Williams syndrome, positive behavioural support, dignity and person centred care and equality and diversity. Staff worked in teams with people they supported and they received any training about their specific needs.

Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. They said they were well supported to carry out their caring role. Staff members comments included, "We have 'shape your future' (supervision) sessions every other month," and, "We talk about any service issues." Staff said they could approach the registered manager and the service manager at any time to discuss any issues. They also said they received an annual appraisal to review their work performance. This was important to ensure staff were supported to deliver care safely and to an appropriate standard.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and wellbeing of people. All staff were involved in the handover. Staff comments included, "Communication is effective," "We have a verbal handover," and, "We use a communication book and diary as well."

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. People required different levels of support. Some people received support from staff to help prepare or make a meal and drinks. People's records showed the support people required. A person commented, "I go out shopping for food with staff." A staff member commented, "We support some people to make their meals."

People who used the service were supported by staff to have their healthcare needs met. Records showed

people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from General Practitioners (GP)s, opticians, dentists, speech and language therapists, behavioural team, nurses and other personnel. Staff told us they would contact the person's GP if they were worried about them. Written guidance was available for staff with regard to people's support requirements. Examples in two care plans included, "I can pull the care call myself, if I feel unwell," and, "I can tell staff if I feel unwell." Peoples' comments included, "I was at the hospital for a check-up this morning," and, "I am going to the doctor's now." Relatives' comments included, "Staff call the GP if [Name] is not well," "They take [Name] to the dentist," and, "Staff make appointments for [Name] and go with them."

People told us care workers always asked their permission before carrying out any tasks. At home visits we saw care workers checked the person was happy for them to proceed as they provided support to the person. We saw people's care records contained signed consent forms, and that care plans and contracts were signed by them or their representatives to keep them involved.

People who used the service were involved in developing their care and support plan, they identified what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. A relative told us, "I attend meetings if a decision has to be made for [Name]."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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). We checked whether the service was working within the principles of the MCA.

The registered manager and staff were aware of the processes to follow where it was felt a person's normal freedoms and rights were being significantly restricted. Within the Independent Supported Living (ISL) houses some people did require constant support to keep them safe. The registered manager was aware the deprivation of liberty standard authorisation process was not applicable within the supported living environment as people were tenants in their own house. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity. We were told this process had taken place for two people and we saw the documentation for one person where a relative was the court appointed deputy for the person and a deprivation of liberty authorisation was in place to keep them safe. For other people the registered manager told us they had alerted the local authority where people's liberty was being restricted and they were waiting for the local authority to process the applications.

Good

Is the service caring?

Our findings

People spoke positively and spoke well of the care provided by staff. They told us staff were kind and caring. During the inspection there was a calm and pleasant atmosphere in the houses. Staff interacted well with people. Peoples' comments included, "I love it here," "The staff are great," "The staff are very kind, they listen," "Staff are my friends," and, "It is brilliant here." Relatives' comments included, "Staff are kind and caring," "They (staff) are very good and very friendly," "Staff are excellent we are more than happy," and, "Staff are fantastic, they know [Name] well."

People who used the service were supported by staff who were kind, caring and respectful. During the inspection we saw staff were patient in their interactions with people and took time to listen to them. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, one care plan stated, "I don't like to be rushed." All people's records advised staff how people communicated. For example, one person's support plan stated, "My speech is slow and may not be clear."

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. Support plans advised staff of support people may need and at the same time promoted their privacy. Examples in care plans included, "I want staff to knock on my door first and call my name out loud. If I don't reply or respond staff can then enter the room to check that I am alright," and, "I like my own space in my bedroom." A staff member described how a sensor, which was in use for a person who was at risk of falls, was timed so it gave the person enough time to return to bed after attending to their personal care needs, before staff went into check them. This therefore respected the person's dignity.

Staff supported people to be independent and to maintain some control in their day to day living. A relative commented, "Staff do advise [Name] on things and then [Name] makes their own mind up." Detailed information was in place that provided guidance for staff to enable the person and encourage their involvement whatever the level of need. One person told us, "I like to have control of my life." People told us they were involved and they said they were listened to. They were involved in regular individual meetings to discuss their care and support needs and monthly tenant's meetings took place to discuss the running of the household and to ask people for any suggestions or areas for improvement. Minutes of meetings showed areas discussed included, 'Valuing people, complaints and compliments, money matters, house safety and things that are important to me.'

Written information was made available in other formats to promote the involvement of the person and to help them understand. For example, visually by use of pictures or symbols if people did not read or use verbal communication. We saw evidence of this with the complaints procedure, meeting minutes and the information pack people received when they started to use the service.

The registered manager told us advocates would be used where a person needed to have additional support whilst making decisions about their care if people did not have relatives to provide advice and support to them. Advocates can represent the views for people who are not able to express their wishes. They told us an Independent Mental Capacity Advocate (IMCA) had become involved, as required by the MCA, because a person had needed some support with regard to their placement and the IMCA had worked with the person. A staff member told us, "[Name] had an advocate for their money."

Good

Is the service responsive?

Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. Some people attended a day placement full or part time. Records showed there were other activities and entertainment available for people. For example, theatre trips, shopping, concerts, gardening, football, bowling, going to discos, trips to the country and coast and meals
out. Relatives' comments included, "[Name] likes to go out in the car, horse riding and for meals," "[Name] goes to the social club and for meals out," "[Name] goes out a lot and also has one to one time with staff which they enjoy," and, "[Name] is more dependent now but is still always going out for coffee and other activities." Peoples' comments included, "I like to go on day trips," "I go to the cat café in Gateshead," "I want to see Mary Poppins at the theatre, I've been to see Mama Mia."

People were supported by staff to go for days out either individually or in a small group. A day trip to Edinburgh Zoo was being arranged with some tenants across two households. Other day trips included to Harrogate, Beamish and Leeds Christmas market. People also had the opportunity to holiday in this country or abroad. One person told us, "I want to go to London." A staff member told us, "[Name] went on holiday with a travel company that provides the support worker and they went to Amsterdam and another time to a safari park in Kent." Other holidays included to Blackpool.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. We were told if there was a vacancy in the household a long process took place to check that people wanted to live at the house and that they were compatible with people who already lived there. The induction included visits such as tea time and overnight visits and was carried out at the pace of the person.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Support plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. Support plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. Examples in support plans for personal hygiene included, "I need to be reminded to wear my glasses and to clean them," and, "I can clean my teeth on my own but need prompting to do this."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, records included, "I can crochet and knit," "I like to grow tomatoes in my greenhouse," and, "I like going to watch Newcastle United." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Staff at the service responded to people's changing needs and arranged care in line with people's current needs and choices. Records showed regular meetings took place with people. Monthly meetings took place

to discuss menus and activities. People and relatives said they were supported and involved in planning their care. Meetings were held to review people's care and support needs and aspirations. A relative told us, "[Name] has support plans and I go to the reviews."

Records were in place that were regularly reviewed to reflect people's care and support needs. We had concerns that although staff completed a dairy for each person they did not complete a daily entry that documented their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences. We were told by staff that it would be completed for anything that was non-routine. In one household a person had attended a hospital appointment but there was no reference in their diary to the outcome of the appointment or the follow up letter that had been received that included advice from the assessment. The information from the assessment had not been transferred to a support plan. Staff when asked however, were aware of the information and the need to monitor and provide additional support to the person. The registered manager told us that this would be addressed.

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. For example, one care plan recorded, "I go to the pub for a meal with my family." Some people had visitors every week or were supported to visit their relatives. A relative told us, "I can visit any time and [Name] is supported to telephone me."

People had a copy of the complaints procedure that was produced in a way to help them understand if they did not read. Tenant's meeting minutes showed people were reminded at their monthly meetings of how to complain and people were asked if they had any concerns, comments or compliments. A record of complaints was maintained. Two complaints had been received since the last inspection and they had been investigated and resolved. Relatives' comments included, "I know who to speak to if I ever needed to complain," and, "Everything is fine, I haven't made any complaints."

Good

Is the service well-led?

Our findings

A registered manager was in place. They had become registered with the Care Quality Commission in 2012.

The culture of the service promoted person centred care, for each individual to receive care in the way they wanted and to be helped to maximise their potential. Staff were made aware of the rights of people with learning disabilities and their right to live an 'ordinary life.' Information was available to help staff provide care the way the person may have wanted, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the houses we visited was open and friendly. Staff and relatives spoke positively about the registered manager and the organisation. They said they felt well-supported. Comments included, "The managers are approachable," "We can always ask for advice," and, "I feel well-supported." Relatives' comments included, "The manager is helpful, if I have any niggles I just ring the manager up and we sort it out," "We are very happy with the way the service is managed," and, "Manager is a good support." Most people said, "The service could not be improved at all."

Staff told us they thought communication was good and they were kept informed. Staff who provided 24 hour support to people told us they received a handover from the staff member at the change of duty. This was to make them aware of any changes and urgent matters for attention with regard to the person's care and support needs. A communication diary was also used to pass on information and recorded any actions that needed to be taken by staff. Staff told us and meeting minutes showed staff meetings took place regularly. They said they could give their views and contribute to the organisation' running. One staff member commented, "We have a staff meeting every two months." Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

Newsletters were distributed from the national head office to staff to make them aware of what was happening within the national organisation. Monthly newsletters were distributed at regional level to make staff aware of initiatives and to keep them informed of organisational events within the region. As an organisation that promoted the rights of a person with learning disabilities there was a resource library where accessible information could be accessed in an easy read format or DVD for people to inform them about issues such as advocacy, bereavement, communication, bullying, education, consent, health and many other topics.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a range of monthly, quarterly and annual checks. They included finances, the environment, medicines and care documentation. Medicines management and finances were checked on a daily, weekly and three monthly cycle. Other weekly audits included health and safety, security, fire safety and documentation. Three monthly audits were carried out and they included documentation, observation of care practice and risk awareness. Regular audits were carried out by the

service manager and registered manager to check on the quality of service provision. The service managers put information into a continuous compliance tool (CCT) for quality assurance purposes each month and this was audited by the registered manager to analyse information. The management team also visited households to observe and speak with people who used the service as well as check the environment and documentation.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw that surveys had been completed by people who used the service in 2016 and the results were positive. A relative commented, "I receive surveys to complete." The results of surveys were analysed by head office and we were told any action would be taken as required to improve the quality of the service. If any trends were identified an action plan was produced which was circulated to individual houses so any required action could be taken by the service manager of the house to improve service provision.