Dimensions (UK) Limited

Dimensions 22 Mill Croft

Inspection report

22 Mill Croft
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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 21July 2015. At the last inspection on 10 July 2013, the registered provider was compliant with all the regulations we assessed.

Dimensions 22 Mill Croft is a purpose built single storey home for up to six people with a learning disability, although only four people are resident there at present. 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. However, one of the bedrooms has been made into a sensory room and another into a store room. There is a garden at the rear of the property and car parking at the front.

The service had a registered manager 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.

Summary of findings

We found people lived in a safe environment. Staff completed risk assessments to ensure there was guidance in how to minimise the risks posed to people from their environment and from daily living tasks. Equipment used in the service was checked and maintained.

Staff had received training in how to safeguard people from the risk of abuse or harm. There were policies and procedures to guide them in what to do if they witnessed abuse or they had any concerns about poor practice.

We found there were sufficient staff employed in the service to meet people's current needs. Staff had been recruited safely and received an induction, training and on-going supervision to ensure they were confident when supporting the people who used the service.

We found people had their health care needs met and had access to a range of professionals in the community. People received their medicines as prescribed, which helped to maintain their health.

Staff supported people to make choices. We found when people had been assessed as lacking capacity to make their own decisions, staff had worked within best practice and current legislation. There was a bath but no shower, which could potentially limit people's choices. This was mentioned to the registered manager to address in future redecoration and refurbishment plans.

We observed people enjoyed their meals and were supported appropriately by staff when required.

We found people were treated with dignity and respect and supported to be as independent as possible. Their needs were assessed and care was provided in a person-centred way. The staff approach was observed as sensitive, caring and friendly. People took part in activities within the house and accessed external facilities to help them take part in community life.

We found there was a system to monitor the quality of service provided to people who used the service. This included analysing accidents and incidents so learning could take place to prevent reoccurrence. Checks were carried out by senior managers so they could assure themselves of the quality of care delivered to people.

We found the environment was clean and tidy and suitable for people's needs. Some exposed woodchip in the kitchen would make kitchen surfaces and cupboards difficult to keep clean and some areas of the garden needed tidying. This was mentioned to the registered manager to raise with maintenance personnel.

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.

Staff had policies and procedures to guide them in how to safeguard people from abuse and harm. They knew the actions to take and who to contact if they became aware of abuse or poor practice. There were risk assessments in place to help staff minimise risks to people and aid their independence.

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

People received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

People's health care needs were met. They had access to a range of health care professionals in the community and had annual health checks by their GPs.

People's nutritional needs were met. Staff prepared a varied diet and supported people to eat meals of their choice and preference. Any concerns about people's nutritional intake were referred to a dietician.

Staff supported people to make choices about aspects of their lives. When people were assessed as not having capacity, best interest meetings were held to discuss options. Any restrictions on people's lives were carried out in line with best practice and in a 'least restrictive' way.

Good

Is the service caring?
The service was caring.

Staff demonstrated a positive and caring approach in their interactions with people who used the service. They provided information and explanations prior to completing care tasks with them and involved people in discussions.

People were treated with dignity and respect and enabled to be as independent as possible.

Good

Is the service responsive?
The service was responsive.

People received care that was person-centred and tailored to their individual needs and preferences.

People had access to activities and external facilities to help them take part in family and community life.

There was a complaints process in place and people felt able to raise concerns. The complaints process was written in easy read format to help people understand how to make a complaint.

Good

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

Good

Summary of findings

There was an open and supportive culture within the organisation and the staff team. Relatives of people who used the service felt able to express their views.

There was a system in place to monitor and improve the service provided to people and to learn from incidents that affected their welfare.

The registered manager was aware of their responsibilities and accountabilities.

Dimensions 22 Mill Croft

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 July 2015 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, we checked our records to see what notifications had been sent to us. This provided us with information about how the registered manager dealt with incidents that affected the people who used the service. We also contacted the local authority safeguarding and commissioning teams. They told us there were no outstanding concerns with the service.

During the inspection we observed how staff interacted with people who used the service and how they administered medicines. 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 registered manager and four care support workers. Following the inspection we spoke with three relatives, a social worker, a district nurse and a regular visitor to the service.

We looked at daily recording of care and support provided to all four people who used the service and assessed two care support files in depth. We also looked at other important documentation relating to the four people who used the service such as their medication administration records [MARs]. 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 looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, training records, the staff rota, 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 of people who used the service told us they thought their family members received care that was safe. They also said there was sufficient staff on duty to support them. Comments included, "Oh yes, we do think they care for her well. We are quite happy with the care", "I'm sure she is safe there; the staff seem competent" and "I have no qualms about the service at all."

Health and social care professionals said, "Yes, the staff are always alright", "They have a good approach and knowledge of the service users is really good" and "It's a good environment, clean and really nice."

We found staff had policies and procedures in place to guide them in how to safeguard people from the risk of harm and abuse. They had completed safeguarding training and in discussions, staff accurately described the different types of abuse and what signs would alert them that abuse may have occurred. The registered manager and staff knew what to do if they witnessed incidents of abuse or poor practice. The registered manager was aware of their responsibilities in referring any incidents to the local authority safeguarding team and Care Quality Commission.

We spoke with the registered manager about how they monitored risk, accidents and incidents to help prevent them reoccurring. We found risk assessments were in place for specific issues that affected the health and welfare of people who used the service. These included mobility, falls, bathing, nutrition and health issues such as epilepsy and swallowing difficulties. Risk assessments also included the use of equipment such as the hoist, a specialist bath, bed rails and wheelchairs. One person's care support file had detailed, pictorial information about how they were to be moved and handled. Staff had been used for the demonstration to guide the team in how to hoist the person safely. Each person also had a personal emergency evacuation plan which detailed how they would be moved out the building safely and quickly in any emergency situation.

In discussions, staff were aware of the risk assessments and management plans and could describe how they assisted people to minimise risks at the same time as ensuring a degree of independence. Comments included, "We put support in place to assist people to do as much as they can for themselves in the least restrictive way", "One person has a crash mat [on the floor by the bed] instead of bedrails as they would climb over them" and "One person has sensor mats in both chairs so we can get to them when they stand up; they're at risk of falls if we don't get there quickly."

We found staff were recruited safely and checks were made prior to staff starting work in the service. Documentation included, application forms, so gaps in employment could be explored, references and disclosure and barring register checks to see if people were excluded from working with vulnerable adults. There was a record of the interview process and a 'rapport building assessment' to test out how potential staff interacted with people who used the service during an introduction to them.

We found there were sufficient numbers of staff on duty to support people. There was a minimum of two staff on duty each day with an additional one to two members of staff employed for certain hours for one to one support and to ensure people could access the community. There was one person on duty at night and another member of staff who completed a 'sleep-in' duty. Staff told us that when they were fully staffed, there were no issues. They said, "This is one of the best jobs I have ever had; It's calm and not rushed, not task orientated at all."

We found people received their medicines as prescribed. The medicines file had information about how people preferred to take their medicines and what discussions had taken place with GPs about these preferences. Staff maintained good stock records and the medication administration records [MARs] showed they signed when medicines were given to people. During administration of medicines, we observed staff check the MARs against the medicine due at that time. They told the person what the medicine was and gave it to them in their preferred way. There were epilepsy management plans for the use of rescue medication and protocols for when people took medicines on a 'when required' basis such as for pain relief or anxiety.

We did note that some people had several creams prescribed and body maps would help to improve clarity for where they were to be applied. The registered manager told us they would address this with staff. We saw the temperature of the room where medicines were stored often reached above storage recommendations. A fan was used and staff opened the window but the room was small.

Good

Is the service safe?

We discussed this with the registered manager and a possible alternative storage space was identified. The registered manager told us they would address this as soon as possible.

We found the service was clean and tidy with no malodours. There were some areas of exposed woodchip on kitchen work surfaces and drawers, which would make them difficult to clean. It was mentioned to the registered manager to address with senior management. Staff had access to personal protective equipment such as gloves, aprons and hand sanitizers. There was liquid hand soap and paper towels in toilets and bathrooms and hand wash signs to prompt staff on good hand-hygiene.

Equipment used was maintained and serviced in line with manufacturer's instructions. Staff had a maintenance book to highlight any repairs or shortfalls with equipment so they could be reported to the company's estates team for action. The book indicated when action had been taken.

Good

Is the service effective?

Our findings

Relatives of people who used the service told us they felt their family members were well looked after. Comments included, "They send for the doctor when needed and they let me know", "She is eating well; I don't worry on that score", "I'm kept fully informed" and "Yes, it's a good service." They also commented on staff skills, "I'm sure staff know what they are doing; they invite me to reviews" and "They do seem well trained."

Health and social care professionals said, "Staff seem to know what they are doing; I have confidence in the team leader", "They pick up issues very quickly and know their behaviour well – their emotions and their moods" and "They tend to follow instructions. Once our documentation was different to what they had; there was a communication issue but the case holder went in and spoke to them and got it sorted."

We found people's health care needs were met. Care support records showed they had access to GPs, district nurses, dentists, opticians and chiropodists. People had checks with other health professionals when required such as consultants, speech and language therapists, dieticians and specialist nurses. Each person had a health action plan which detailed health issues and how these were to be met and by whom. Staff said, "The GP is very good and does annual LD [learning disability] reviews." Staff described how one person was prone to urinary tract infections, so they had a plan in place for early detection and GP response. Staff said, "We keep them hydrated, watch out for symptoms and try to catch it early" and "We know the changes in behaviour that means they may be starting with one [infection] and start the antibiotics."

We found people's nutritional needs were met. Each person had an assessment, risk assessment and care plan regarding their nutritional needs. These included likes and dislikes. Staff developed the menus and prepared meals each day; some people had food which was provided in a specific texture to aid swallowing. We observed the lunchtime experience and saw staff supported people at an appropriate pace when required; they were attentive during the meal, gave people visual choices and offered drinks. We saw one person was provided with a plate guard which helped them to eat their meal independently. Staff recorded what people ate and drank each day; this enabled them to monitor food and fluid intake and to act quickly if there were any concerns. Staff said, "If we have any concerns we ring the GP and refer to a dietician; no-one is under the dietician at the moment."

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 four applications to the local authority but these had not been finalised and authorised as yet. The care plans showed the least restrictive means were used to keep people safe. For example, the registered manager described how chair sensor mats and a light beam in one person's bedroom were used to support their risk of falls. These were the least restrictive options which enabled the person to maintain their safety, and a quick staff response when needed, without undue restrictions of bedrails, and lap straps when seated in chairs.

Training records showed relevant staff had completed training in the Mental Capacity Act 2005 [MCA] and DoLS. We saw when people were assessed as lacking capacity to consent to care and make their own decisions, best interest meetings were held to discuss options. We saw the decision-making involved relatives, staff at the service and relevant others. Staff described how there had been a best interest meeting to discuss whether one person should have a specific health check but it had been decided it would cause the person too much distress.

Staff were clear about how they gained consent when carrying out day to day care tasks. They said, "We provide explanations and watch for facial expressions; we make sure people know we are there so nothing comes out of the blue", "[Person's name] can explain to us what they want. They take us to the kitchen and guide our hand to the cupboard where the biscuits are. Sometimes it can be trial and error to find out what it is people want", "They would let us know if they didn't want to do anything" and "If they declined care we could try different staff, explain what we are trying to do, encourage them; If that failed we would leave them for a while and approach later."

Consultation had been held with people's family and commissioners regarding the use and payment of two vehicles, which were for communal use by people who

Good

Is the service effective?

lived in three services managed by the registered provider. Some people were able to use the vehicles more often than others but all paid the same amount each week for the upkeep of them. This was not an equitable system and following review the regional managers were to ensure payment for the use of the vehicles was in line with individual use.

Staff confirmed they had completed training suitable for their role. They said, “We have classroom training for things like moving and handling, hoist, epilepsy and CPR [cardio-pulmonary resuscitation]; the rest are on line”, “Induction incorporates learning disability training” and “We have a responsibility to monitor when our own training is due; we go into the portal [computerised system] and check.” Records were held on a computerised system and we saw this was updated when training was completed; the system indicated when refresher courses were required. The training record showed staff completed training considered mandatory by the registered provider. These included, infection prevention and control, basic food hygiene, health and safety, data protection, fire safety, first aid, equality and diversity, person-centred care and safeguarding. Staff completed annual competency checks on their medicines management. There was also service specific training such as epilepsy management and autism awareness.

Staff told us they felt supported and received supervision in meetings with their line manager. They said, “Management are supportive; they are always available and approachable” and “We have one to one supervision every six weeks; we discuss support for service users, training, the team and bring up any concerns. We have action plans with set dates.” Records showed us staff received annual appraisals.

The environment consisted of a single storey building and met people’s current needs. Corridors were wide and had a grab rail on one side. There were also grab rails in the bathroom and toilet. There was a ramp at the front of the building and level access from one of the rooms into the back garden.

Good

Is the service caring?

Our findings

Relatives told us they thought staff were caring towards their family members and treated them with respect. Comments included, "The staff are kind and caring; they bring [persons' name] home once a week for two hours and we go down there when we can. There are no restrictions and we can drop in whenever we want", "I am pleased with the care and the way they address [persons' name]. They support her when she is walking", "When they bring her to visit me, they show her the greatest respect" and "The staff are lovely."

Health and social care professionals said, "During reviews, I have seen positive interactions", "The team leader has a good approach and knowledge of service users", "Staff are attentive, absolutely. All staff constantly talk to the service users, are friendly and they are always getting them cups of tea to drink", "There are no problems with staff respecting privacy and dignity" and "They are well looked after; I would happily have any relative of mine in the bungalow."

We observed positive interactions between staff and the people they provided care and support to. During assessments it was identified what was important to the person who used the service and how best to support them. This was taken into account when identifying key workers. The registered manager described a 'matching process' that was carried out to ensure key workers were assigned to people who they could connect with. Relatives told us they too, had built up relationships with their family members key workers. Staff realised the importance of maintaining family connections and arranged for people to visit their relatives or to meet them for lunch at a place of their mutual choice. Relatives told us they appreciated these gestures.

We observed staff provided information and explanations to people during tasks such as assisting with meals, moving and handling and administering medicines. They looked for non-verbal communication and tested out what they thought the person may want. We saw staff speak to people in a calm way, getting down to their level and making eye contact when they were sat in wheelchairs or comfortable chairs in the lounge. It was clear from observations that the staff knew people's needs well but they still asked questions and gave people choices. For example, at lunchtime, we saw staff showed people two choices for dessert and waited until they had pointed to the one they wanted. Staff used pictorial signs to help people with their choice of meals. There were menus on display in pictorial format.

We observed staff support people to maintain privacy and dignity. Each person had their own bedroom which afforded them privacy. These were very personalised with items that were precious to people. We saw staff knocked on doors prior to entering. We saw people were appropriately dressed for the weather, their clothes and nails were clean and their hair had been combed. We observed staff assisted people with clothes protectors at lunchtime. There were privacy locks to toilet and bathroom doors. Care support plans reminded staff about the need to promote privacy and dignity. We asked staff what the words 'dignity and respect' meant to them and how they promoted these values during their interactions with people. They spoke about knocking on doors before entering, keeping people covered up during personal care tasks and respecting people's choices and right to privacy. The registered manager told us one person who required leg dressings would have these changed by the district nurse in the privacy of their bedroom.

Staff described how they supported people to be as independent as possible. This involved them assisting people to make choices about their clothes, times of rising and retiring, what they wanted to eat and what they wanted to do during the day. They described how one person helped out with minor household chores and others participated by watching staff complete them. Staff also described how they supported people to maintain friendships made with people who lived in the other bungalows managed by the registered provider; friends had recently been invited to a tea party at the service. Staff said people really seemed to enjoy it and it was going to be organised again.

We saw staff had completed meetings in the past with people who used the service but these had proved difficult in ensuring everyone was fully involved in decisions. The registered manager and staff told us they were trying a new system of recording how people were involved in decisions. This was based on more day to day choices and decision-making to reflect people's involvement throughout the day including activities and accessing community facilities.

Good

Is the service caring?

There was information about advocates on display in the service; we saw advocates had been involved in attending reviews and supporting people to make decisions about their care and treatment.

We saw people's personal records were stored in a cupboard and secured when not in use. Staff files were located in an office and held securely. Computers were password protected and training records confirmed staff had completed a data protection course. There was a staff office to use when holding telephone conversations or private discussions about the care provided to people who used the service. We saw in records that that each member of staff signed to say they had read and understood the registered provider's policy and procedure on maintaining confidentiality.

Good

Is the service responsive?

Our findings

Relatives told us staff were responsive to their family members needs and felt they were able to access the community when they wanted to. They also said they would feel able to raise concerns with the registered manager if necessary. Comments included, "She goes to church services on Thursday mornings; I am pleased about that", "They bring [person's name] to visit me, we have a meal and she is relaxed and happy", "I don't go to the service but they bring [person's name] to me. I look forward to meeting her and keeping in touch", "The staff are lovely; I have no complaints", "She looks happy which is all I need to know", "If I had a complaint, I would go to Kirsty [registered manager]" and "I have known Kirsty for a lot of years now; I would tell her."

Health and social care professionals also said they knew who to raise concerns with and mentioned the registered manager by name.

Records showed people's needs had been assessed and care support plans had been developed to guide staff, so they could assist them in a person-centred way. The care support files had a quick reference guide to remind staff as to what was important to the person and how they preferred to be supported. The 'getting to know you better' documentation went into detail in a person-centred way, for example, what was working for the person or not, how they wanted their life to be like and what changes they may want to make. It described what a good and bad day would look like for the person, their family connections and what gifts and skills they possessed. The care support plans included an exercise to match staff to the person, for example what skills and experience staff would need to support the person.

We saw individual care support plans for a wide range of needs and situations. For example, we saw care support plans were very detailed in describing how people's health, mobility, personal care, communication and nutritional needs were to be met. There was step by step information to guide staff when supporting people to bathe and when transferring them with the use of a hoist. Support plans described how people communicated their needs, such as when they wanted to get out of their wheelchair, when they had finished a meal, when they were content or when they were about to have a seizure. There were detailed plans to support people to manage their epilepsy and guidance for staff in administering rescue medicines for repeated seizures. We saw the care support plans were written using sensitive and appropriate language that reminded staff of respecting dignity, maintaining privacy, ensuring choice and seeing the individual behind the care support tasks. Documentation described people's routines and gave staff good information in how to support people in the way they preferred.

Staff said, "We have a person-centred structure to the day; it helps to stimulate people. We have to gauge what people like and try new things. We have to make care individual to the person." They also said, "Take [persons' name], she needs to come round gently and slowly in the morning. When she is upset or in pain we know this as she takes herself to her bedroom" and "There are no set times for getting people up in the morning; we start with whoever is awake first." We saw people had reviews of the care support plans; these were documented in a person-centred format. The record of the review included what the person had tried during the time frame, what had been working well for them, what could be better and what they wanted to do next.

We saw the registered manager had responded to one person's risk of repeated falls. They had installed two sensor mats in the person's chairs and a sensor beam in their bedroom for use at night. This enabled staff to respond quickly to the person's needs and help to minimise the risk of falls. We saw staff had also liaised with people's GP to discuss what food their tablets could be put on top of, for example a small amount of jam or yoghurt; this was not done in a covert way to hide the tablets but to make them more palatable.

We saw people had individual care support plans for activities and access to the community. These had to be managed to ensure sufficient staff were available to accommodate the activities. We saw people joined walking groups, went swimming and shopping, attended tea-dances, line dancing and church, had lunch out and had visits to their relatives and local parks. The staff told us they aimed for two community activities each week for each person. There were also in-house activities such as participation in or watching household tasks like preparing a meal, making beds, dusting or laundry. Records showed people enjoyed a hydrotherapy bath in the service,

Good

Is the service responsive?

received a massage, staff read newspapers to them, they watched films, listened to music and used the sensory room. Staff confirmed they had time to sit and have a cup of tea and a chat to people.

We saw people had holidays planned; three people had several days away booked in August and September. Staff told us one person preferred 'days out' instead of 'days away' from home. They said, "She gets distressed if away from home so we plan day trips instead."

We saw each person had a 'patient passport'. This provided up to date information for medical and nursing staff should they be admitted to hospital. This helped the person have a smoother transition between the service and hospital.

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.

Good

Is the service well-led?

Our findings

Relatives all knew the name of the registered manager and other members of the staff team. They said they had known some staff for many years which had helped with continuity. They also said they were kept well-informed about their family members. Comments included, "She has had the same key worker for a lot of years" and "I ring her [key worker] and they keep in touch. They send me minutes of meetings and keep me really informed."

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 22 Mill Croft and two other services in close proximity. We observed the registered manager knew the needs of the people who used the service. She greeted them by their first names and her approach was friendly and considerate. We found the registered manager was aware of their responsibilities and accountabilities. We received timely notifications of incidents that affected the welfare of people who used the service. The registered manager ensured people completed work station assessments and carried out return to work interviews with staff, following sickness absences. They said the return to work interviews had impacted positively on sickness levels.

The registered manager described a culture of the organisation as one of support, openness and learning from mistakes. In discussions, it was clear they had sound values about putting the needs of people who used the service first and supporting the staff team. Comments from staff included, "Yes, you can raise concerns; if you are not happy with the team or staff in other bungalows you have other people to turn to" and "There is a counselling service which is not just for work related problems." They also said, "Head office are coming to a team meeting. We have to do a presentation to them on personalisation." Staff also said they were happy with the budget they received for the preparation of people's meals and confirmed there were no restrictions and had never been told they had overspent.

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 organisations 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.

Staff told us they worked well together as a team and were supported by the registered manager and assistant locality manager. Comments included, "It's good working here", "We have a really good team", "The assistant locality manager is always available and approachable" and "The manager's workload is intense but you can ring her and she will make time for you."

Staff spoke about how communication was maintained to ensure they knew what was going on in the team and in the organisation. They said, "We have team meetings, newsletters and the website." We also saw there were handovers where staff exchanged information about the people they supported and the tasks they had carried out during the shift. They completed daily records and reported on aspects of people's lives, the activities they had completed and personal care delivered to them. We saw staff received supervision meetings and appraisals where information was exchanged and action plans agreed, and there were memos when required.

We saw there was a quality monitoring system in place. This consisted of audits and seeking people's views about the service provided. Internal audits included checking care files, how finances were managed, stock checks of medicines, hand hygiene assessments and the environment. There were also audits completed by the organisations 'compliance team'. Staff confirmed this and said, "Senior managers did a big audit six months ago on the environment, medicines, support plans, menus and observations of practice. They fed back results; positives and any actions."

The registered manager told us feedback forms for relatives, regarding their views about support provided to people, were due to go out to them soon. We saw this was built into the appraisal system for staff; the feedback was recorded on their appraisal record and discussed with them.

Good

Is the service well-led?

The registered manager described how the analysis of accidents had improved practice and monitoring for one person who used the service. For example, the installation of grab rails in the corridor and an extra one in the bathroom, plus sensor mats and a sensor beam in the person's bedroom. This enabled staff to respond quickly. We saw accidents or incidents were completed by staff on-line and the registered manager had to see them to sign them off as checked. They analysed the accident and determined the level of risk and what action was to be taken. They said that how the on-line information was recorded could trigger escalation to the registered provider's quality assurance team. This would be monitored and contact made with the registered manager to check how the accident or incident had been managed.

We found some areas of the garden were in need of tidying and the toilets in need of redecoration; these should have been picked up in environment checks. There was also one bathroom with a specialised bath but no shower; this was the room used for bathing by the four people who used the service. There was a shower room but it had a raised lip to the shower which would limit access to those people without good mobility; currently it was used for staff following sleep-in duties. Staff told us people who used the service all enjoyed a bath each morning but they recognised this was the only choice available. This was mentioned to the registered manager to discuss with senior managers and to build into future redecoration and refurbishment plans.