Dimensions (UK) Limited

Dimensions Baily Thomas House Haysoms Drive

Inspection report

Haysoms Drive
Greenham
Thatcham
Berkshire
RG19 8EX
Tel: 01635 41426
Website: dimensions-uk.org

Date of inspection visit: 22 October 2014
Date of publication: 21/04/2015

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

We inspected Dimensions Baily Thomas House Haysoms Drive on 22 October 2014. This was an unannounced inspection.

The service provides respite care support for adults or young people living in the community who have a learning disability. People may also have associated physical or behavioural difficulties. The service provided respite support for a total of 38 people as well as outreach support for 13 people. The home itself can accommodate up to six people for respite care at any one time. There were no concerns identified at the previous inspection in August 3013.

The service had a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

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.

The staff knew how to keep people safe and understood how to report any concerns around safeguarding. Relatives and external healthcare professionals told us people were safe and cared for with dignity and kindness. The people we saw during the inspection were unable to tell us verbally whether they felt safe but their body language, facial expressions and behaviour suggested they felt relaxed and well cared for.

Staffing levels were adjusted to meet the needs of the individuals being supported at any one time and management support or advice was always available. The service had sought external advice and support from health professionals, parents and care managers where necessary, to maintain people's safety and wellbeing.

Staff recruitment was thorough. Staff received the training and support they needed and medicines were safely managed. Respite care packages were tailored to meet people's assessed needs. People and their families were involved in planning their care. Care plans were person-centred and identified individual likes, dislikes and preferences. Care plans were amended when necessary to reflect people's wishes and changing needs.

Communication systems between staff were good and staff knew how to communicate with people and gain their consent to care and support. The home provided people with meals they enjoyed and involved them in its preparation as much as they wished. Staff worked with people in a respectful and caring way, treating them as adults and involving them in decision making. Care plans reflected people needs and wishes.

The home provided flexible care support and responded effectively to crises and emergencies by offering respite at short notice when this was needed. The needs of people and their families were taken into account when planning respite stays. People's individual cultural or personal preferences were supported. People's views and those of their families were sought, about the quality of the service and acted upon. The opinions of staff and health professionals were also sought. People were told about and knew how to raise any complaints and any issues raised had been appropriately responded to.

The service was well managed and monitored by the registered manager who responded appropriately to any identified issues. Communication, training and support were all provided effectively by management and staff development was encouraged and supported. Staff and relatives said the registered manager was approachable and supportive. External health professionals, care managers and parents told us that any concerns had been listened to and addressed. The provider also monitored the operation of the service through quarterly audit visits and any identified issues were added to their "service improvement plan" and the action taken was monitored to ensure the issue was addressed.

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.

Good

Management and staff understood how to keep people safe and knew how to raise any concerns.

Staffing levels were adjusted according to the needs of the people being supported on any day to ensure their needs were met.

Behaviour that may challenge was well managed to minimise the risk to the individual and others.

Staff knew individuals and their needs well in order to maintain their safety.

Is the service effective?
The service was effective.

Good

Staff and management understood people's rights with regard to mental capacity and consent and Staff had received relevant training to help them to communicate with people.

Respite care packages were tailored to meet people's needs and people were involved in planning the care provided.

Care plans were person-centred and amended when required to reflect changes in people's needs.

Staff received the training and support they needed to meet people's needs. Support was sought from external healthcare professionals when necessary.

Is the service caring?
The service was caring.

Good

Staff treated people in a caring and respectful way, knew them well and enabled them to make decisions and choices.

People's care plans and the care provided reflected their individual needs, wishes and preferences and supported people's rights.

The service provided caring support to people at difficult times in their lives. People's individual support needs, friendships and any potential conflicts were taken into account when planning respite times.

Is the service responsive?
The service was responsive.

Good

External professionals and families told us people's needs were met flexibly and the service responded quickly to emergencies.

The needs of people and their parents were addressed when scheduling respite stays.

People were supported flexibly according to what they indicated they wanted to do on the day, rather than just following a pre-set plan. Their cultural and other needs were provided for.

Summary of findings

People and their relative's views were sought through regular surveys and they were told about how to raise concerns or complaints. Any issues raised had been resolved promptly and effectively.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who managed the unit effectively by providing consistent guidance, monitoring and support. The provider also monitored the service to ensure that standards were maintained.

Matters that arose from monitoring audits were addressed by the registered manager.

Communication, training and support systems were used effectively to manage and develop staff, who were encouraged to discuss, question and challenge practice.

Where practice issues had emerged they were dealt with appropriately by the registered manager. Queries raised by people, their parents or external professionals were addressed appropriately.

Dimensions Baily Thomas House Haysoms Drive

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.

We inspected Dimensions Baily Thomas House Haysoms Drive on 22 October 2014. This was an unannounced inspection, which meant the staff and provider did not know when we would be visiting. The inspection was carried out by an Adult Social Care inspector.

Before we visited the service we checked the information we held about the service. No concerns had been raised since our last inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The people present during the inspection mainly communicated their needs through other means than verbal speech. During our inspection we observed how staff and the young adults interacted and saw how people communicated their wishes and were cared for. We observed how staff supported people with activities throughout the day. We sat with people during lunch to see how they were supported with their meal and spent time interacting with two of the people present on the day.

We also spoke with the registered manager and three staff about the day-to-day operation of the home. After the inspection we spoke with the parents of four young people receiving respite care at the service to obtain their views. We also sought the views of six external health professionals and three care managers who have had recent involvement with the service. We viewed a range of care records for the people supported including three care plan files, risk assessments and records relating to the operation of the service.

Good

Is the service safe?

Our findings

People were safe in Baily Thomas House.

Staffing ratios in the unit were calculated based on a baseline of one staff member to three people. This was increased where risk assessment identified the need for one-to-one staffing or more. The registered manager ensured that no more than two people requiring one-to-one support were receiving respite at any one time. This meant staffing levels were varied according to the assessed needs of the people present to keep them safe.

In practice, the unit had at least two staff on duty at a time, with additional management support during office hours. This ensured that even during periods of lower occupancy, staffing levels were safe. Sleep-in staff were provided at night. Where necessary, waking night staff were provided to maximise people's safety.

The staff numbers were sufficient to meet people's needs safely. There were three full-time care staff vacancies at the time of this inspection. However, only 15 shifts had been covered by agency staff in the previous three months so continuity of care was maintained. The service could access additional Dimensions 'bank' staff or agency staff where shortfalls could not be covered by other team members.

We looked at the recruitment records of two staff who started working at the service recently. All the checks necessary to ensure staff were safe to work with people were completed. However, the home had not received the information they needed to ensure the agency staff were suitable. This information included confirmation the recruitment checks, identity and training of the agency worker and also that they had a current Disclosure and Barring Service (DBS) criminal records check. The registered manager obtained copies of this information the day after the inspection to enable her to ensure that agency staff had been subject to the required checks to safeguard the people supported.

Staff understood how to 'whistle-blow' if they had concerns about practice and also knew how to respond to any safeguarding concerns. Parents told us their son or daughter was safe at the home, that they enjoyed going there and would be able to indicate to them if they were unhappy about being there.

One emergency respite care bed was provided to enable a prompt response to individual needs. This helped keep people safe by enabling their needs to be met during times of individual or family crisis.

Staff had all completed medicines training and undergone a detailed competency assessment by the registered manager or deputy manager, which was updated on a six-monthly basis. When a medicines error had been made, staff had been re-trained and reassessed on their competency to administer medicines. Improvements had also been made to the storage system to avoid putting people at risk. Where people were supported with their medicines during their stay, this was managed appropriately. Medicines were only accepted in original pharmacy-labelled containers and quantities were recorded and stored appropriately in a locked medicines cabinet. Two staff signed for each item administered. One person held their own inhaler to use when required.

The medicines procedure gave appropriate guidance on responding to any medicines refusals. People's rights regarding medicines consent were respected and safeguarded where they did not have capacity to consent to medicines. For example, discussions had been held with the GP and family and a referral made to the learning disability team, regarding a 'best interests' decision about one person's medicine. No one received their medicines covertly and the registered manager understood the 'best interests' process if the need arose. One person took medicine in a spoonful of yoghurt to assist them with taking it but this was appropriately prepared in front of them so the process was not concealed.

People's support plans included risk assessments where relevant. Risk assessments were enabling and sought to minimise the risk associated with people's chosen activities, rather than limit them. Although staff had previously received training in a recognised behaviour management programme, the registered manager told us that physical interventions as such were not necessary at the moment. Behaviours which challenged or might affect people's safety were managed using distraction and other de-escalation techniques.

People's safety was also managed by planning the group of people being supported at any one time to avoid unnecessary conflicts and with the support of external

Good

Is the service safe?

psychologists and other professionals. If necessary, a behaviour management plan was drawn up with their support, so that staff adopted a consistent approach to minimise and manage instances of challenge.

We spoke with visiting healthcare specialists, including psychologists, speech and language team, community psychiatric nurse, occupational therapist, physiotherapist and care managers from the learning disability team. All were very positive about the way the service met people's needs in a flexible way to keep them safe. One health professional told us staff were very competent to meet people's needs. Another health professional told us the staff allowed them free access to people, (with their consent) to check their welfare. Health professionals told us staff contributed well to multi-disciplinary meetings to discuss peoples' needs. A member of the psychology team praised the staff for their adaptability to meet a wide range of needs and told us they always consulted with external professionals when this was necessary and were happy to raise any concerns they had.

Good

Is the service effective?

Our findings

People were either referred for respite care by the local authority or this was privately funded by families. The local authority assessed the needs of the people whom they were funding and set the level of respite being funded. The actual pattern of respite stays was planned in consultation with parents.

The people receiving respite care each had a "support plan". This identified their needs, risk assessments, methods of communication and details of their likes and dislikes and how they liked to spend their time. We looked at a sample of three care files.

The people supported were able to make day-to-day decisions about their care and consent to the support offered. For example, one person had given consent for the use of bed-rails at night to keep them safe from falls. People also chose the staff member they wished to support them, particularly with personal care.

If there was any doubt regarding a person's capacity to consent this was discussed with parents or the care manager to arrive at a 'best interests' decision should it be necessary. Where assessments of mental capacity were required, these were referred to the local authority to be carried out. The Mental Capacity Act 2005 provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff had received training in various forms of non-verbal communication so they could understand people's needs, respond to them and enable choice. We saw staff interacted effectively to support people with their individual needs, showing they understood people's methods of communication. People were given time to process information and communicate what they wanted. Their needs were responded to in a timely way and staff communicated effectively and worked as a team. People's body language and facial expressions showed they felt involved and valued and shared humour was evident between staff and the people supported.

None of the people receiving respite support would be able to leave the home safely without support. Door sensors had therefore been fitted to alert staff if someone left the building. The registered manager had made Deprivation of Liberty Safeguards (DoLS) referrals to the local authority for each individual in relation to the door sensors and responses were awaited. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

During the handover between the morning and afternoon shifts we saw staff shared information effectively to ensure good continuity of care. They discussed events, activities and care issues and passed on information about what people had eaten. The use of a written handover record and a communication book helped to ensure information was effectively shared among the staff team.

The registered manager used tools to help match the needs of the people supported to the personal characteristics or interests of particular staff. This was said to have worked very well, particularly for people who were supported one-to-one by staff.

New staff completed an induction training programme when they first started and then on-going training. Staff also attended supervision meetings and received other support through team meetings. The provider supplied training to staff based on the needs of the service and the people supported. The staff had all attended the training necessary for their role as well as additional specialist training related to people's needs. This included training about the communication methods used by the people they worked with.

For example the service had recently begun supporting one person who used The Picture Exchange Communication System (PECS) to communicate their wishes. Staff had since received training from the speech and language therapy team (SALT) in how to support the person via this system. Information and ideas had also been provided by the person's parents to help staff provide effective support.

The registered manager and deputy manager had been trained to deliver moving and handling training. This training could therefore be refreshed with individuals or with the whole team when needed. Training had also been provided on epilepsy management and an appropriate epilepsy emergency plan was provided for one person. Staff confirmed they had received a thorough induction and all the necessary training and felt equipped to meet people's needs.

Good

Is the service effective?

Staff attended regular monthly supervision meetings with their line manager and had annual performance appraisals. Staff told us their supervision and appraisals were constructive and supportive. They said the registered manager was: "readily available for advice, anytime". The appraisal process was thorough and included obtaining feedback from colleagues, the people supported and their families to provide a broad assessment of the staff performance. Staff felt listened to and said they were supported to give their opinions and question things. Staff also told us monthly team meetings took place. These meetings were used to discuss people's needs, staff and management issues and to review events. Some people had had a say in who was employed to support them, through their involvement in the staff recruitment process, by meeting applicants and attending interviews.

The registered manager reported that the service dealt with limited instances of behaviours that may challenge and was not using any forms of physical intervention. Support with managing such behaviours was sought from external professionals including psychologists if required. An example was given where the service had recently sought the support of the psychology team with managing the behaviours of one person. They were due to visit to discuss the concerns and devise a plan to support staff with managing the behaviours. The provider had trainers qualified to deliver a recognised programme of physical intervention training, should it be required in the future.

A menu was planned in advance. This was to allow for people's varied times of arrival and departure. People's likes and dislikes were recorded in their care plan and considered when planning the menu and staff were familiar with the meals which individuals enjoyed. People were offered alternatives if they chose not to have the meal from the menu, to ensure they had something they wished to eat. People had opportunities to provide feedback about the meals through regular surveys which included questions about the food, or during monthly service user meetings. We saw examples in meeting minutes where food-related issues had been raised and addressed.

None of the people supported were at risk of malnutrition or had swallowing difficulties. However, one person had blended or soft foods by their own choice. The service had access to the SALT team for advice and guidance on any swallowing issues. Support from a dietician had been sought in the past. None of the current people had other specialist dietary needs. People were involved and supported to take part in meal preparation and other associated tasks to whatever extent they wished. Some people were given hand-over-hand support to enable them to do this as part of encouraging skills development.

Routine healthcare needs were generally addressed by family. The involvement of staff was usually limited to the administration of prescribed medicines. Additional support was available from external health professionals if required.

The health professionals we spoke with described the service in very positive terms. One health professional felt that Baily Thomas House was a very good service overall and told us the staff sought specialist advice when they need to. Two other health professionals described the service as: "Effective and person-centred". One health care professional told us staff were always willing to work with healthcare professionals in order to achieve good outcomes for clients and the quality of care was high. Care managers had no concerns about the service and said they responded effectively to people's needs and to any recommendations made. Healthcare professionals also told us that the people they worked with were happy to come to Baily Thomas House. One said: "Service users said they enjoy attending the service" and added: "They are involved in day to day tasks appropriately by staff". Another health professional told us: "Family carers and clients generally speak very well about the service and find it invaluable".

Parents were also positive about the support provided to them and their son or daughter and said the staff understood their needs. They told us the staff communicated well with them verbally as well as through the communications log. One parent said the staff: "Tried hard to meet the person's needs and supported them to make choices and decisions about their activities". All four of the parents said their son or daughter enjoyed going to Baily Thomas House. One parent praised how the service had adapted its way of working in response to their son or daughter's needs. This was in terms of adapting the welcoming arrangements to enable a smooth transition into the home. Parents also felt that the staff were happy to be contacted and listened to their ideas and suggestions.

Good

Is the service caring?

Our findings

We found the service provided to people to be caring. We saw during their day-to-day interactions and through the way they talked about people during handover, that staff respected the people they supported. People were described positively and treated as valued individuals. Throughout the day we saw positive communication and shared humour.

Staff offered people choices in individual ways they could understand and gave people sufficient time to process information. Staff involved people in conversations and people's smiles and demeanour showed they enjoyed the interactions. Staff gave us examples of how they respected people's dignity. For example by offering same gender care support where this was preferred. The registered manager described how a particular behaviour was managed and this also indicated a respectful approach.

Where staff were supporting an individual one-to-one, they sat and engaged with them for the duration of the activity to provide continuity of support. People were involved in planning their care during respite stays as far as possible and additional information had been obtained from parents about their needs.

We found that staff had provided caring and effective respite support to people through difficult placement transitions such as between children's and adult services, in some cases over an extended period. People with more complex needs had these met successfully, with additional support from external health specialists when required.

People were supported in accordance with their care plan. Care plans were written using appropriately caring and respectful language and described the way support should be offered and how people's views and consent could be sought. Staff spent time getting to know each person to enable person-centred care. Each person's preferred communication methods were supported to ensure their needs were met and enable them to make choices about their care.

Staff supported people to communicate and make choices. People were treated with dignity and we were given examples to illustrate how their privacy was respected. The staff matching process used to maximise compatibility between staff and people supported also helped to enhance the caring process. People were encouraged to be as independent as they wanted and to have as much involvement in their care as they wished. People's records were held securely to respect their right to confidentiality.

Discussion with and observations of staff, showed they knew about people's likes and dislikes and relevant history and understood how to communicate with them. Staff also described the support they provided in appropriate caring terms using language which suggested respect for people's individuality and rights. Staff did not talk over people and involved them in conversations. Staff were enthusiastic and motivated and responded promptly to any changes in people's mood or engagement. The body language we saw suggested people enjoyed the contact they had with staff and felt respected and well cared for.

The registered manager told us that when planning people's respite stays they considered friendships and common interests so that friends and those with similar interests could attend together. In this way respite stays were more likely to be enjoyed and compatible activities and interests were better provided for. Where people were known not to get along, their respite patterns were planned so as to prevent avoidable conflicts. The designation of one bed for emergency respite meant that the service could and had responded promptly and flexibly in times of crisis.

Family members were free to visit the service at any time. However, this could be confusing for someone supported for a short-term respite stay so it did not usually happen outside of dropping off and picking up times. Some parents did keep in touch during respite stays via telephone.

External healthcare professionals praised the care provided by the service. One told us their clients were all very happy to stay there and parents felt their sons or daughters were well cared for. The staff team were said to do their best to maintain as much independence as possible for people. The service was also described as welcoming and hospitable. One person explained how an emergency admission was effectively managed by the service because the staff had treated the person with respect and kindness. The person had told the healthcare professional that they had also seen this kindness extended to others there and had regularly asked to return to the unit. One care manager told us more people wanted respite care there than there were places.

Good

Is the service responsive?

Our findings

People were supported take part in activities or access the community based upon their individual wishes. Staff sat with some people and supported their activities one-to-one, while others engaged in activities independently. One person was supported to do some drawing while another spent time playing a computer game. A selection of garden activity equipment had been obtained following the recommendations of a relative, which we saw was popular with some of the people attending the unit.

Care plans noted people's individual interests so staff knew about and could support these. People's cultural, spiritual and individual needs and preferences were met where this was desired. The registered manager gave examples of cultural or individual needs being met responsively by the service. For example the option to have showers instead of baths and for one person, the choice to have a soft or pureed diet.

Other dietary needs had also been met as required. To minimise the potential for confusion of a person with dementia, the person was assigned the same room each time. The room was also prepared ahead of their arrival, with items familiar to the person. People had opportunities for skills development within the context of what was possible during respite stays. For example through being supported and encouraged to do their own laundry, make beds or prepare meals. Staff responded flexibly to people's individual wishes at the time rather than just following written care plans. People were offered choices and given opportunities to decide for themselves what they wished to do.

Care plans had recently been revised into a new format, more suitable for a respite care setting. They were updated as and when necessary rather than to a set schedule. This was appropriate given than some people's respite sessions might be widely spaced throughout the year.

The service planned the patterns of respite support offered to people flexibly, based on appropriate criteria. These included the specific needs of each individual and the level of respite funded either by the local authority or by self-funding families. The service tended to be over-subscribed at weekends due to the preference for weekend respite. This was managed effectively by sharing out weekend respite between those using the service as fairly as possible and offering a very flexible weekday service.

It was evident that respite times were offered flexibly based on meeting family's individual needs and not on convenience to the service. This was shown by the various times of arrival and departure we saw for people attending for respite, which fitted with people's day-to-day arrangements such as working hours or travel needs. The registered manager gave examples of where particular short-notice flexibility had also been provided in response to family needs.

Parents were happy that they had been involved in decisions about the schedule of respite provided. One of the care managers told us: "The management try to be as flexible as possible in accommodating our clients and their varying levels of need". Another said: "I found the staff team very receptive and responsive to my input as an external professional". One external health professional told us they had been impressed by the way the service had adapted to meet the needs of a person whose needs were significantly different from the majority of the people supported. They praised the way the staff had managed some quite challenging behaviours.

People's views and those of their parents and external professionals were obtained through surveys provided in appropriate formats. A pictorial format was used to get the views of people within the home. This process was in addition to the organisation-wide surveys undertaken periodically by the provider. The advantage of the registered manager's survey was that it provided specific feedback about the quality of this service. The most recent local survey had been completed in July 2014. Representative comments from parents and professionals included: "Baily Thomas House is the respite [the person] thoroughly enjoys going to", and the service is: "very supportive to the service user and all of the service user's family". All of the survey respondents confirmed they knew how to complain if they had any concerns.

People had regular meetings within the service within which their views and any concerns were obtained to be addressed. Parents felt they had been involved appropriately in planning their respite care. One relative said: "the staff are all lovely" and another described them as: "flexible and accommodating". Two people described

Good

Is the service responsive?

the service as: “like a home from home”. Relatives felt that their son or daughter was supported to make real choices using their preferred communication method. A relative told us that any issues they had raised were resolved in discussion with the manager.

Relatives said they had been informed about the complaints procedure but had not had to use it recently. One said that when they had raised an issue previously the service had been very open and looked into it promptly. They described the service as being: “on the ball”. Another parent told us the staff had always communicated clearly with them and kept them informed. One relative was happy that their son or daughter was given a room at the front of the unit to meet their particular interests regarding the view from the window. Another parent described the responsiveness of the service, by saying it: “Had adapted to people’s needs” and added that support had been provided at short notice if necessary and that the service had: “never let me down”.

The complaints procedure was available in a pictorial format and could also be provided in a compact disc or video format on request to meet individual needs. The procedure was introduced to people on admission and a copy was on the notice board in the hallway.

The manager told us that all of the people supported would be able to indicate if they were unhappy about something, which confirmed what parents had said. The service user meeting minutes included details of some issues raised by people within the unit and their resolution. The manager said that the majority of issues were addressed in discussion before becoming a complaint.

Only one recent complaint was logged. This related to the home’s inability to meet a respite booking request and was responded to appropriately. One of the care managers we spoke with told us that staff had taken the time to discuss an issue raised by one relative around patterns of respite and had made changes which they were happy with.

Good

Is the service well-led?

Our findings

The home had a registered manager. The manager and deputy were present in the home Monday to Friday as well as undertaking some support shifts themselves. This provided them with opportunities to observe staff care practice directly. The manager told us that any issues noted would then be raised within supervision or team meetings. The manager and deputy provided regular monthly supervision to staff and all staff had received a performance appraisal in May 2014.

Regular team meetings also took place. Staff and management had regular opportunities to discuss practice issues, as indicated by the records of the regular team meeting. These meetings were used to discuss and promote good practice. The manager was due to attend an upcoming manager's conference to continue developing her leadership skills and gain further knowledge on team leadership.

Feedback from staff confirmed that supervisions appraisals and team meetings were regular and were a constructive forum for discussion. Staff felt they could discuss issues openly and that if they raised a concern it would be addressed by management. One staff member said it was: "an open team" and another told us they: "Felt supported" and: "Work as a team". Staff also felt able to question practice and that discussions took place about how best to meet people's needs. They told us the manager was always available to discuss anything if necessary. Staff and the manager told us the provider also had an out-of-hours on-call service to provide advice and support. The manager told us about one instance where the on-call service had been contacted for advice and this had been provided as required.

A staff survey was carried out to seek the views of the team about how the home was operating. Staff were set goals as part of their supervision and appraisal to develop their skills and improve the service provided. Staff could also raise any issues or concerns with the area manager or via the provider's staff welfare officer or counselling service.

The manager monitored the training records of staff to ensure that training and competency checks remained current. Where an issue had arisen around a medicines error, the manager ensured staff were appropriately re-trained and had their competency reassessed. The medicines receipt and storage procedure was changed to reduce the risk of reoccurrence.

The manager delegated lead responsibility for some areas to staff in the team, including monthly health and safety audits. Additional training was provided to staff with these responsibilities to equip them with the skills they needed. People's lead responsibilities were then monitored through their supervision.

The provider's own compliance team carried out quarterly audits of the quality of the service and provided copies of reports to the manager. Four such visits had taken place in the previous 12 months. The service had achieved high scores from these quality audits. As a result the provider considered the home was being well managed and required less intensive monitoring. The reports from quality audits included an action plan and items identified were followed up through inclusion in the "service improvement plan" to measure progress. Records showed that actions were noted and issues were addressed. The manager told us that the latest audit results were due to be discussed with the staff team in team meetings to highlight any issues raised. The unit's maintenance log showed that identified issues relating to on-going repairs and maintenance were addressed. The manager undertook surveys to obtain the views of the people supported, their families and staff. Monthly meetings also gave people in the service the chance to share their views.

No safeguarding events had arisen regarding the service since the previous inspection. The manager had notified the Care Quality Commission where required, regarding reportable incidents. The notifications indicated that appropriate steps had been taken in response to each event and the situations had been managed well.

The manager and staff maintained the confidentiality of people's records by them being kept securely when not in use. Personal information was made available to staff only where it was necessary to enable them to meet people needs.

Parents felt the service was well managed and said they had been involved appropriately in planning support for their son or daughter. One parent described the manager as: "open to suggestions as to how to improve things" and added that the manager: "was always available on the

Good

Is the service well-led?

phone". Relatives confirmed that their views had been sought and that they had been made aware of how to raise any concerns should they have any. The service worked with external organisations to ensure up to date practice, for example the Voluntary Organisations Disability Group, their own local authority and the safe guarding team with regard to Deprivation of Liberty Safeguards (DoLS) applications.

External professionals were positive about the openness of management. One health professional told us complaints were addressed in a timely manner and resulted in changes in practice where necessary.