Scope

Belvoir Lodge

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

We inspected the service on 4 October 2016. The inspection was unannounced. Belvoir Lodge provides accommodation to five younger adults with learning and physical disabilities. The service is open plan to accommodate people who use wheelchairs. There is an overhead tracking system for the hoist, so that people can move around the service. On the day of our inspection five people were using the service.

We carried out an unannounced comprehensive inspection of this service on At the last inspection on , 29 September 2015 we asked the provider to take action to make improvements to the way they monitored the quality of the service, and this action had been partially completed.

The service had a registered manager in place at the time of our inspection. 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 were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to protect them from harm.

People were supported by enough staff to ensure they received care and support when they needed it. Medicines were managed safely and people received their medicines as prescribed.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions and staff knew how to act if people did not have the capacity to make decisions.

People were supported to maintain their nutrition and staff were monitoring and responding to people's health conditions. People lived in a service where staff knew them and their preferences listened to them. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting. People were supported to enjoy a social life. Concerns were responded to appropriately.

Systems in place to monitor the quality of the service were not always effective. People were involved in giving their views on how the service was run and there was an open and inclusive culture.

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 and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

There were enough staff to provide care and support to people when they needed it.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision.

People made decisions in relation to their care and support and where they needed support to make decisions they were protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Good

The service was caring.

People lived in a service where staff listened to them and cared for them in a way they preferred. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting.

Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support. People were supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor the quality of the service were not always effective.

The management team were approachable and people were involved in giving their views on how the service was run.

Belvoir Lodge

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 the service on 4 October 2016. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. 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.

People who used the service had limited verbal communication and so we relied on observations and spoke with the relatives of two people to get their views. We spoke with four members of support staff, the service manager and the registered manager. The service manager was responsible for the day to day running of the service and was overseen by the registered manager who did not work daily in the service. We looked at the care records of two people who used the service, medicines records of five people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the service manager and registered manager.

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.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm. We observed people who used the service and the way they interacted with staff and it was clear that people were comfortable with staff. People smiled when staff approached them and looked happy to see them. One relative we spoke with told us they felt their relation was safe and said, "[Relation] would let me know if [relation] was unhappy there." The relative went on to explain that they observed their relation's behaviours before they were due to go back to the service after a visit. They told us, "It is not just the multidisciplinary meetings which are held for [relation] but the holistic approach which keeps [relation] safe."

People were supported by staff who recognised the signs of potential abuse and how to minimise the risk of people coming to harm. The provider told us in their PIR that staff received safeguarding training and we saw records which confirmed staff had received this training. staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm or abuse and to escalate concerns to the registered manager or to external organisations such as the local authority. Staff were confident that any concerns they raised with the registered manager would be dealt with appropriately. Scope has a safeguarding team and any incidents were notified to them to be assessed for action needing to be taken and any changes which may be needed in the service.

The registered manager had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the registered manager carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

Risks to individuals were assessed and staff had access to information about how to manage the risks. For example two people were at risk of choking and we saw there were care plans in place detailing how staff should support these people and minimise the risk of them choking. There were a range of risk assessments in place to inform staff how they should support people and minimise the risks they faced. These risks included scalding, using transport and the use of bedrails to prevent them from falling. One member of staff described adhering to the risk assessments in place stating, "If the risk assessment quotes that an activity needs two staff members then this is what happens. I would never put anyone at risk."

People were living in a safe, well maintained environment. Records showed that there were systems in place to assess the safety of the environment such as fire safety checks and legionella checks. There were emergency evacuation plans in place for each person so that staff would know how to support people in the event of an emergency such as fire. Staff had been trained in relation to health and safety and how to respond if there was a fire in the service. The service manager told us that newly recruited staff were given a health and safety induction on their first day and we saw this happen in practice with the member of staff who started working in the service on the day we visited.

People received the care and support they needed in a timely way. We observed there were staff available to support people when they needed it and had the time to spend with people for social activities, including

escorting people out into the community. The service manager had sought additional funding for one person due to their needs changing and more support being needed. This had been agreed and the person was now in receipt of one to one support for certain hours during the day.

The registered manager told us there was a baseline staffing level but that staffing levels were determined according to what was happening on the day such as social activities and appointments. Staff we spoke with said they felt there were enough staff to meet the needs of people who used the service.

People were not able to manage their medicines and so they relied on staff to do this for them. A member of staff told us there were always adequate members of trained staff on each shift to administer medication. Staff we spoke with had an in-depth knowledge of what support people needed to keep them safe in relation to their medicines.

We found the medicines systems were organised and that people were receiving their medicines when they should. Staff were following safe protocols for example completing stock checks of medicines and assessing the temperature of where the medicines were stored. Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines. There were audits carried out on a regular basis to ensure staff were following safe protocols.

Good

Is the service effective?

Our findings

People were assisted by staff who were trained to support them safely. One relative we spoke with told us they felt the staff knew what they were doing. They told us, "They (staff) get trained." We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately.

People were assisted by staff who were supported to have the skills and knowledge they needed to support them safely. Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely and they felt that it was appropriate in giving them the skills and knowledge they needed to support the people who used the service. We saw records which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and first aid. Training was also given in relation to the individual needs of people. For example two people had a health condition and staff were trained in how to monitor this safely. Another person needed support with a specific ongoing health condition and we saw staff received training in how to monitor and manage this safely and were adhering to National Institute for Health and Care Excellence (NICE) guidance, aimed at improving health and social care.

Staff were given an induction when they first started working in the service. The service manager told us that new staff were completing the care certificate. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. We spoke with a member of staff who had just started working in the service and they confirmed they were going to be completing this qualification. They told us they had commenced a two week period as part of their induction where they would be shadowing other staff and learning about the support needs of people who used the service.

People were cared for by staff who received feedback from the management team on how well they were performing and were able to discuss their development needs. Staff we spoke with told us they had regular supervision from the registered manager and were given feedback on their performance and we saw records which confirmed this. The supervision process was very detailed and linked into staff development and annual appraisals, ensuring objectives were set and followed up. There was then an end of year review covering the objectives and giving each member of staff a performance rating.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported to make decisions on a day to day basis. We observed staff gave options to people who used the service and people made the decision in relation to how and where they spent their time. Staff spoke of the importance of getting people's consent prior to delivering personal care.

People were supported by staff who had a good knowledge and understanding of the MCA. The staff and service manager we spoke with understood their roles in relation to supporting people with decision making and making best interest decisions under the MCA. They recognised the importance of people's families and health and social care professionals being involved in any decision making process. A relative commented that they felt very involved in making decisions in their relatiion's best interests.

People's support plans contained clear information about whether people had the capacity to make their own decisions and we saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed.

People can only be deprived of their liberty to 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service manager had made applications for DoLS where appropriate. For example, one person had been assessed as requiring support from staff if they went out into the community and they were not free to leave the service alone. There was an up to date DoLS authorisation in place for this person. The service manager had also made further DoLS applications for other people to ensure that they were not being deprived of their liberty unlawfully.

People who sometimes communicated through their behaviour were supported by staff who recognised how to avoid this and to respond in a positive way. There were plans in place informing staff what might trigger behaviour and how staff should respond. Staff we spoke with had a very good understanding of people's behaviour and how best to support them. One staff member commented that the service was successful with minimising people communicating through behaviour due to staff knowledge of likes and dislikes, combined with watching and observing mannerisms before a situation arose. The staff member told us, "We are very responsive and try to get to the bottom if it. We find the way to help." They were able to describe an example of this when a person had recently become agitated and their quick thinking of getting a fan to cool the person down as they felt heat might have avoided a difficult situation.

People were supported to eat and drink enough. We observed people were given enough to eat and drink and there were plentiful stocks of food in the service. One relative we spoke with told us they felt their relation was supported with their nutrition and described the meals as, "Healthy and home cooked." We observed people being given lunch and saw they were given support to eat and staff gave the support at a level and pace which was appropriate to the individual they were supporting. We observed people who required specialist diets such as a pureed diet were given these and where people needed a thickening agent in their drinks, this was done in line with guidance in the person's care plan.

People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw one person had been assessed as being at risk of malnutrition and staff had sought advice from a nutritionist and were following their advice such as person frequently and recording their food intake. We received feedback from a health professional involved in the nutritional care of one person and they told us that they felt nutrition was managed well that staff contacted them if the person's weight went outside of the agreed range.

People were supported with their day to day healthcare. We saw people were supported to attend regular appointments to get their health checked. We received feedback from a health care professional involved in the care and support of some people who used the service and they told us that people were supported to attend the clinic by care staff who are well informed and knowledgeable about the individual and their current health needs. They told us staffalways brought detailed records with them (e.g. seizure records and medication charts.) They also said staff contacted them in between clinics if they had any concerns about an individual's health needs to ask for advice or to request an early review.

Staff sought advice from external professionals when people's health and support needs changed. For example staff had involved a physiotherapist for one person to support them with their movement. We saw there was a range of external health professionals involved in people's care, such as occupational therapists, epilepsy nursing team and the Speech and Language Therapy Team (SALT).

Good

Is the service caring?

Our findings

The provider told us in the PIR that they approached all of the support provided from a position of care and respect and that the staff team were trained to work in this way at all times. They told us that the individual was put at the heart of everything staff did and that the regular observations of practice were carried out to ensure staff worked to this ethos with supervisions being used to challenge and bring about improvement. Information from with relatives and health professionals, observations we carried out and records we saw confirmed this to be the case.

One relative told us, "[Relation] wouldn't be there if I wasn't happy with the organisation. I know [relation] is cared for." We observed staff interactions with people and we saw staff were kind and caring when they were supporting them. People looked relaxed and comfortable with staff and smiled when they approached them. We observed one person had fallen asleep when staff were supporting people to get ready to go out for the morning. We saw a staff member approached the person and gently woke them up by talking quietly, stroking their arm and hand and offering reassurance whilst the person was waking. The staff member said they didn't want the person to miss the opportunity to go out as they would be disappointed. Once the person was awake the staff member asked them if they still wanted to go out, which they did. It was clear from the way staff spoke about people they had a great fondness of them, and spoke about their achievements in a positive way. One member of staff told us, "It's not me, I am just here, and It's them achieving something." Another member of staff told us, "I like to make a difference every day to help them live a fulfilling life." A relative we spoke with confirmed this in the comments they made about how their relation was supported.

People were supported by staff who knew them well and knew how to ensure people were given choices, for example in relation to how they spent their time and what they ate. It was clear from our observations that staff knew people well and had a good understanding of their preferences and how to communicate well with them. We saw staff knelt down in front of people prior to speaking with them and ensured they were at eye level. Staff we spoke with had a very in-depth knowledge of people's likes, dislikes and support needs. They were able to describe them in a positive and meaningful way, detailing how they supported individuals in line with their preferences and how they were supported to communicate. One relative told us, "They know [relation] well and what [relation] likes"

This relative also confirmed they felt their relation was offered choices and commented they felt, "The ethos of being person centred is embedded and understood within the organisation." They described reading the communication diary, used to communicate between staff and relatives, and seeing entries such as, "We asked [person] if [person] wants to do…" We received feedback from a visiting health professional and they told us, "They (staff) involve the client in choosing meals for that week."

We saw in people's care plans that their preferences for how they were supported were recorded, along with their likes, dislikes and what was important to them. This included how they communicated, giving guidance to staff on how to support them to communicate their choices and needs. One member of staff we spoke with told us, "It's utterly up to them (people who use the service) what they want." Staff described

different techniques they used to communicate choice such as visual prompts and said that because they knew people well they were able to understand their individual communication by the noises or gestures they made. A new member of staff had been out for the morning with other staff and people who used the service and they confirmed this, and told us they had observed people making choices and these being respected. They told us that what they had read in people's care plans matched how staff had supported them. Staff also described using photographs and leaflets to support people in making choices. People had been supported to personalise their bedrooms in colour schemes of their choice and had items they had chosen to have.

The service manager described a new incentive which staff were developing with the Speech and Language Therapy team (SALT) to support people to have more autonomy through an innovative communication tool. They described how this was being used and developed to enable people to verbally communicate their choices at restaurants and to enable them to ask for things, for example to ask for a bus ticket when going out into the community. One person had been empowered to use the system to turn their music system on and off and the service manager said the person was clearly excited about this.

People were supported by staff who recognised the importance of positive relationships. Relatives told us they felt welcome to visit when they wished. One relative told us, "You get a real welcome, it has a homely feel, I feel of part of a family." Staff described ways they supported people to stay in touch with their friends and family, including the use of technology for video calling. We saw that care plans detailed friends and family important to people who used the service and records showed they were supported to keep in touch.

People had opportunities to follow their religion and culture. One person had been supported to attend a place of worship which had been a part of the person's culture, however staff had reported that the person's responses to this indicated they did not enjoy attending. Staff had sought out another local place of worship, which was a quiet place and the person had responded positively to this and so staff offered this alternative to the person on a regular basis.

We spoke to the registered manager about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. The service manager told us that an independent advocate visited the service every fortnight and spoke with all of the people who used the service, who wished to speak with them. This was to ensure people had access to an advocate whenever they wished to use one.

People were supported to have their privacy and were treated with dignity. We observed staff respecting the privacy and dignity of people who used the service such as knocking on doors prior to entering and speaking discreetly about matters of a personal nature. We spoke with a relative about whether their relation was treated with dignity and they told us they felt staff respected this and said, "[Relation] always looks clean, tidy and smart."

Staff were able to verbalise the organisation's core values of dignity and respect. One member of staff told us one of them was to be, "Treated how you would like to be treated." Staff spoke about ensuring they protected people's privacy when supporting them with personal care such as closing curtains and doors. There were signs on toilets doors reminding staff of the need for 'time and dignity.' The service manager told us that one member of staff was a dignity champion and said they observed other staff working in the service to ensure they were following the dignity values.

Good

Is the service responsive?

Our findings

People and their relatives were involved in planning and making choices about their care and support. The provider told us in the PIR that support plans were written with people who used the service and other interested parties who were in their circle of support. One relative we spoke with described attending meetings to discuss their relation's care and support and said, "I am consulted about [relation]'s care and involved in discussions. I am very proactive and feel listened to in meetings." We saw in people's care plans that staff had recorded people's preferences and how they would like to spend their day. This included their hopes and dreams for the future and how these would be achieved.

People were supported by staff who were given information about their support needs. We saw each person had a care plan which was written to give staff detailed information to enable them to meet the needs of the individual. We saw that people's care plans contained information about people's physical and mental health needs and guided staff in how to support them. For example one person had a programme of therapy and there were detailed plans in place informing staff how to support the person to achieve this. One relative told us, "Each year I believe the care and response to [relation] is much better." We saw there was some conflicting information in the care plan of one person in relation to the support the person needed, however the service manager quickly addressed this and ensured staff were aware of the correct approach.

We saw the care plans were very detailed in relation to how people preferred to be supported and we saw this was followed in practice. For example the care plan of one person stated they liked to be given support with their meals with staff standing on a specific side of them which we saw happen as detailed in the care plan on the day we visited. The person also liked a specific cup for their drinks and we observed the drinks were given in the specified cup.

Although people who used the service had complex needs with physical disabilities staff worked to support people to have some independence. We saw one person was supported to take part in hoovering in the service and each week staff took people who used the service to do grocery shopping. Staff described people enjoying using the shopping scanners in the supermarket and one member of staff described how this was a good way for people to engage and interact. The staff member went on to say, "There's nothing that they aren't involved in."

People were supported to follow their interests and take part in social activities. We saw that people's interests were taken into account for planning individual activities. For example the care records of one person detailed they liked ice skating and staff confirmed that this person was regularly supported to follow this interest. We saw people were supported to access the community and day services. On the day of our visit a group of people went out with staff to a centre which provided specialist facilities and activities for young people with learning and physical disabilities. The centre had specially developed indoor and outdoor facilities to encourage healthy living, learning and life skills and staff told us this was a place they regularly took people as they enjoyed the activities there.

There were activity time tables in place which were developed based on what people liked to do such as

bowling, a gym club and in house activities such as baking and pamper sessions. There was a regular floor programme activity with sensory lights which some people enjoyed and regular movie and popcorn nights. On each activity board there was a notice for staff stating that if people did not wish to participate in their activity an alternative should be offered. We observed this happen in practice when a planned activity was offered to one person, and the person declined. A variety of activities were offered until the person settled for one which we saw they clearly enjoyed. We observed the timetables were followed and the activities scheduled happened on the day we visited. We also saw photographs of people enjoying a variety of activities and annual holidays and the service manager described people being supported to participate in theatre productions. The showed us a new incentive they had implemented for each person which was a sensory story. The stories had been written with people who used the service as the main character and involved sensory touch. For example one person had a story written about them which involved them attending a beauty salon, and they had a selection of items to accompany the story such as nail polish and massage oil. The story involved the use of a new communication tool being used at the service so that people who would otherwise not be able to communicate verbally could vocalise their choices. The service manager told us these were used once a week as an individual activity and that they were working well.

People knew what to do if they had any concerns. One relative told us they felt comfortable in raising any concerns they had with the service manager. They told us they had not had to complain but had mentioned a concern and this had led to the service manager involving an external health professional in the person's support and the issue was rectified. They told us, [The service manager] will try to resolve things within their power."

Staff we spoke with knew how to respond to concerns raised and their need to record and escalate them. We saw there had been one complaint received and this had been recorded, investigated and resolved appropriately in line with the provider's complaints policy. There was a complaints procedure in the service so that people or their representatives would know how to escalate their concerns if they needed to.

Requires Improvement

Is the service well-led?

Our findings

The last time we inspected the service we found there had been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements to the way they monitored the quality of the service. We found this had posed a risk of people who used the service not receiving care and support which met their needs. The provider sent us an action plan detailing who would make the improvements and by when. During this visit we found the provider had made the improvements they said they would, however there were further improvements needed. We saw newly implemented audits were taking place, however these did not align themselves to the online monitoring systems used by the provider and were not as robust as they had been intended to be.

When we last inspected the service we found the quality visits did not include looking at the systems in place to check medicines and equipment safety and did not include auditing the support plans. Themed visits had been introduced to improve this with themes being in relation to health and safety, medicines and people's care plans. We saw there was also a variety of new audits which had been implemented. For example audits designed to assess care planning, care records and medicines. However these did not always identify where there were inconsistencies and gaps in recording. We spoke with the registered manager about this and they took action to further improve the monitoring system, however if the audits had been robust, these issues would have been identified by the provider prior to our visit. Improvements had been made in relation to the safety of medicines, the storage of cleaning agents, assessment of safety and equipment and how people were assessed under the MCA.

We looked at the medicines audits and saw that where issues were identified there was a lack of an action plan in place to ensure the issues were addressed. We also saw audits were undertaken to assess people's care plans and ensure they were up to date, but these had not identified where staff were failing to record some aspects of one person's care and support.

We found there had been improvements since our last inspection in relation to the frequency of risk being assessed, such as in relation to risks of people developing a pressure ulcer and people being assessed under the MCA. There had also been improvements to health and safety in the service and the implementation of equipment checks such as bedrails to ensure these were safe for people to use.

The registered provider had systems in place to oversee the running of the service. These included the registered manager carrying out a monthly quality visit to the service to assess the quality of service people received. We looked at the reports kept of the visits and saw the registered manager spent time talking with staff and observing them support people. They also checked the environment and some records such as complaint and incident records to ensure these were being acted on appropriately. An annual service review was also carried out to look at aspects of the service such as staffing, training and reviews of the care people were receiving. All reports were submitted to the provider so they had an overview of what was happening in the service.

There was a registered manager in post and although they did not work in the service on a daily basis, they

provided support and guidance to the service manager, who was responsible for the day to day running of the service. We observed the service manager interacting with people who used the service and it was clear they had a comfortable relationship and the service manager knew people very well. Staff and relatives told us the service manager was approachable and we observed this on the day we visited. The service manager spent time in the main body of the service and when they were in the office staff entered freely. We received feedback from a visiting health professional and they told us that during telephone conversations with the service manager they had been very helpful and appeared to have taken on board suggestions discussed.

People were supported by staff who received support from the management team. Staff we spoke with told us they were given the opportunity to hold discussions with the service manager via regular supervision meetings and also at any other time they wanted to discuss an issue. One member of staff told us, "There is an open door policy." Staff told us there were also regular meetings held for staff where any issues could be discussed as a team. We saw the service manager had also implemented observations of staff practice in relation to working to Scope policy and their approach and communication with people who used the service.

People were supported to be a part of the local community. Staff we spoke with described relationships they had built with local shops and restaurants and how they had sourced places which could cater for people who used the service in their specialist chairs. A Christmas meal had been booked well in advance to ensure people would be able to go to a place of their choice which was able to accommodate five wheelchair users and support staff.

People who used the service and their relatives were given the opportunity to have a say about the quality of the service. There were meetings held for people who used the service so the provider could capture their views and get their suggestions and choices. We saw the minutes of the last two meetings and saw people had been given the opportunity to give feedback on the service and make choices about activities. Feedback forms had been sent to people who used the service and their relatives in 2015 and the results of these analysed and action taken to address any issues raised. The service manager told us that the 2016 feedback forms were being re-written to improve the content and to make the forms more user friendly. They told us following the inspection that this had now been completed and the forms were in the process of being rolled out.

Scope has designated teams for areas such as safeguarding and health and safety. An online system was used to input any accidents or incidents so these could be analysed and assessed for action needing to be taken and any changes which may be needed in the service. The service manager also used the online system to input any data about events in the service so that the provider was kept up to date with what was happening.