Voyage 1 Limited

Summerfield Court

Inspection report

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Date of inspection visit:
24 April 2018
01 May 2018

Date of publication:
07 June 2018

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

Summerfield Court is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Summerfield Court accommodates up to 17 people in a rehabilitation home for people who have acquired a brain injury. At the time of our inspection, 17 people were using the service. All bedrooms within the home had en-suite facilities and the provider also had an annex with three apartments which provided a more independent living environment for people planning to move into assisted living accommodation in the community.

This inspection took place on 24 April and 01 May 2018. The inspection was unannounced on the first day. This meant the staff and provider did not know we would be visiting. The second day was announced.

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

Records were not always accurate to show when actions had been taken to improve the quality of care being provided and therefore, we have made a recommendation about records management.

People told us they felt safe and staff had a clear understanding of how to protect people from abuse or harm. Safeguarding and whistleblowing policies were in place which staff followed should concerns need to be raised.

Medicines were managed safely and we saw people received their medicines with signatures to show when they had been administered. 'As required' medicines were administered when needed and some people were supported to self-administer.

Risk assessment were completed and regularly updated to reflect people's needs. Accidents and incidents were reported and actions taken to mitigate future risks. Safety checks had been carried out to ensure the home was safe and regularly monitored.

Staffing levels were sufficient to meet people's needs. Robust systems were in place to ensure people working in the home were of suitable character.

The provider followed the Mental Capacity Act 2005 (MCA) guidance with capacity assessments, Deprivation of Liberty Safeguards (DoLS) applications made and court of protection orders followed. Staff also understood MCA guidance and supported people to make decisions when possible.

People were supported with their nutrition and health needs. Specific dietary plans had been created with health professionals for those that required further support. Health care professionals were involved to ensure people were supported in their recovery and advise staff on practice when needed.

Staff received sufficient training to ensure they could support people's needs. Supervisions and annual appraisals were completed to promote development and staff told us they felt supported.

People living in the home spoke positively about the staff that supported them and thought of them as friends. People told us they were involved in all aspects of their care and were provided explanations to ensure they understood their care.

Staff respected people's privacy, dignity and preferences. People's wishes, likes and dislikes were considered when developing care plans and people were encouraged to remain independent to aid their recovery.

Care plans were person centred and focused on people's independence and encouragement to move on from the home to assisted living environments within the community. Care plans were regularly reviewed in collaboration with people who were offered choices about how they wished to live their life.

The use of technology and accessible information was available for those people who needed it and improved communication between people.

Activities were actively encouraged to ensure people did not become social isolated and to support people to partake in hobbies or interests they enjoyed.

People knew the registered manager and felt actions would be taken should any concerns be raised. People and staff told us the registered manager had an open door policy and was approachable.

Audits and surveys were completed to gather people's views and ensure improvements were made however, records did not show the actions taken.

Monthly meetings for staff and people living in the home took place to ensure people could express their views and be informed of any changes within the home.

The provider continuously sought to improve people's quality of life by supporting them in their goals to aid recovery and enhance independence skills to move into the community.

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

This service was safe.

People told us they felt safe and were safeguarded from abuse and harm.

Staffing levels were sufficient to meet people's needs and recruitment systems were robust.

Medicines were managed safely and safety checks were carried out to ensure the premises were continuously being monitored.

Risk assessment were completed and regularly updated. Accidents and incidents were reported and monitored with corrective actions taken.

Is the service effective?

Good

This service was effective.

The principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were met.

Staff were provided sufficient training to meet people's needs and were supported with supervisions and annual appraisals.

People's health care needs were monitored and supported. Staff worked collaboratively with other health and social care organisations.

People received adequate nutrition and hydration to maintain their health.

Is the service caring?

Good

The service was caring.

People were treated with care, dignity and respect. People had positive relationships with staff.

People's care records detailed their wishes and preferences around the care and treatment provided.

People were encouraged to be as independent as possible and involved fully in their care planning. Staff also provided explanations to ensure people understood their care.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and regularly reviewed to reflect people's needs. People's choices and individual needs had been reflected in care plans.

People were encouraged to participate in activities which they enjoyed and were interested in.

Accessible information and technology was used for those who had limited verbal communication.

Complaints were managed effectively with actions taken to prevent future occurrences.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes were in place to monitor and improve services, however accurate records had not always been maintained to show when actions had been completed.

People and staff knew the registered manager and felt confident any concerns would be effectively managed. Meetings were held so people could raise their views and be informed of changes within the home.

Improvements to the service had been made and the home actively encouraged people to become independent to promote their recovery and improve people's quality of life.

The registered manager reported accidents and other notifiable incidents that occurred to the Care Quality Commission.

Summerfield Court

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.

This comprehensive inspection took place on 24 April and 01 May 2018. It was unannounced on the first day and was carried out by one inspector. The second day was announced.

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us. We also contacted the local authority, other stakeholders, and Healthwatch to gather their feedback and views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we spoke with three people who used the service, three care workers, the registered manager and the operations manager. We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at four people's care plans, medicine records, three staff personal files and a variety of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

People living at Summerfield Court told us they felt safe with comments that included, "I've never not felt safe… my keyworker helps me out to the café or pub. He has my best interests at heart" and "I'm very happy here. Staff are very good, I couldn't ask for better." One person in the latest annual survey in August 2017 said, 'I feel very safe living at Summerfield Court and everyone comes to see how I am.'

People living in the home were protected from potential abuse or harm. The provider had robust systems in place for staff to follow and report any abuse. Staff were knowledgeable about the different types of abuse and how to protect people from potential harm. One staff member said, "There are protocols in place to keep people safe not just in the home as this can be in the community. We make sure people are not at risk. My loyalty is to people living in the home. I would tell the team leaders straight away [If they suspected abuse had occurred]."

Staff were aware of the processes to follow should they need to whistleblow. We found a poster in the main entrance which informed people of how they could raise any concerns anonymously and the provider had a whistleblowing policy in place.

Accidents and incidents were managed effectively with actions taken to reduce future occurrences. For example, one person fell and required stiches to their head. Following this the person was reminded by staff to wear their protective head equipment and walking stick to reduce the risk of falls happening. Another incident involved the use of illicit drugs, the police were contacted immediately and the illicit substance removed.

Risk assessments were in place and updated regularly for those people at risk. Assessments provided staff with information about the likelihood of the risks and what impact this could have for example, 'extremely harmful (severe injuries, fatality) and likely (has occurred before).' This helped staff to determine the level of risk and actions that may need to be taken to reduce this and prevent harm.

We saw one risk assessment which focused on nutrition, swallowing, eating and drinking for a person at risk of choking. The person had been assessed by a speech and language team and advice provided for staff to support them. This included, a mashable diet, to be sat upright when eating with support of pillows and staff to remind the person to lift their chin from their chest when eating and drinking to prevent choking. It also stated that the person should remain upright 20 minutes after food and to be supervised whilst eating so that staff could quickly clear airway should this be required.

We saw risk had been managed effectively for example, We saw staff had taken action when a person had once not returned to the home in the time agreed and the police were contacted to ensure the persons safety and was bought back to the home.

The registered manager told us everyone living in the home had access to a call bell which alerted staff if they required assistance or for emergency purposes. People living in the home told us staff arrived promptly

and without delay. One person said, "They come quickly when you call the bell."
Staffing levels were sufficient to meet people's needs. The registered manager told us staffing levels were calculated based on people's dependency. People living in the home told us individual staff members were allocated as keyworkers who were responsible for the person and their needs. This ensured consistency and allowed staff to build rapport with people living in the home.

Some staff felt more staff were needed during times when the home was busy, however this was not always the case. Comments included, "It's been short sometimes and the deputy or manager help out. This isn't on a daily basis just when lots of people take annual leave" and "Staffing is fine, some days understaffed from sickness. It's gotten better in the last year. Other people pick up shifts, we use bank staff." Staff told us bank staff received the same training as they did. One person living in the home told us, "There is always enough staff."

The provider had robust systems and checks in place which ensured people were of suitable character to work with people in a care home. This included pre-employment checks such as references being obtained prior to staff being offered employment.

Systems were in place for the safe management of medicines. Individual medication files included a picture of the person and their date of birth to prevent staff from administering medication to the wrong person. There was a list and picture of all medicines to ensure staff provided people with the correct medicines. Medication administration records (MARs) showed when medicines had been administered or relevant codes used. For example, some people living in the home self-administered their medication with the support of staff and code 'A' was documented on the MAR to show when this had been taken.

Protocols were in place for 'As required' medicines. For example, one person was prescribed paracetamol for pain due to headaches, pain or fever. We saw one protocol which did not identify the reason for why a person required paracetamol other than pain and needed further information. We informed the registered manager of this and they agreed to add further information. People who required creams or lotions had a topical MAR in place along with a body map which provided instructions to staff on how and where to apply the medicines.

Staff had competency assessments to ensure they were competent to administer medicines. Checks within the medication room were completed. This included fridge temperatures and staff had documented the times and dates of when medication boxes had been opened.

One person living in the home had a STOMP (Stopping over medication of people) programme in place. This is a programme designed to reduce people's psychotropic medicines and the initiative was derived from NHS England to ensure good quality of life and not over exposing people to medicines that may not be required. The care plan stated, 'Using psychotropic medications for behaviours is a form of chemical restraint so the aim would be to gradually reduce the dosage in line with the prescriber's recommendations. In conjunction with all relevant professional active support, positive behavioural support, intensive interaction would be provided to manage behaviour.' The purpose of this was to support the person to become more independent using other support methods other than medication to improve their quality of life.

Relevant health and safety checks were carried out which included electrical tests, gas safety, fire checks and risks assessments. Equipment checks were completed on wheelchairs used within the home. Care plans also ensured staff continuously checked that equipment was safe to use for example, 'Staff to ensure equipment is not damaged before use and that all straps are secure.'

People had individual evacuation plans which meant staff knew how to support people to evacuate in the event of an emergency. There was also an infection control policy which staff followed and we saw posters in bathrooms which prompted people to wash their hands to prevent infectious diseases.

Good

Is the service effective?

Our findings

At the last inspection we found appraisals and supervisions had not been carried out on a regular basis. At this inspection we found staff had three monthly supervisions and annual appraisals which followed the provider's policy. Staff told us they felt supported comments included, "[The manager] is really good and approachable" and "The managers have an open door policy, I can always speak to them. We do get support."

People living in the home told us staff had the skills and knowledge to meet their needs. Staff also said they received sufficient training to care for people and additional training when required for example, brain injury specific training and epilepsy training.

An induction programme was in place for new staff which included a workbook, shadowing of more experienced staff, a probation period where their competencies to care for people would be assessed and training. The registered manager told us new staff were given a 'buddy' for support whilst they were completing their induction.

Training was completed by all staff. Some of the training courses included, moving and handling, health and safety, fire safety, safeguarding, MCA, Equality and diversity, nutrition and hydration, infection control, safe food handling, autism awareness, person centre cared, epilepsy and MAPPA (Low level holds) training. The registered manager had a matrix in place to show and monitor which staff had completed their training and when this was due to be updated.

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 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 authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We found the provider had made applications for DoLS and the reasons documented to show why this was needed. For example, one DoLS stated a person may be at risk of absconding and having access to alcohol and drug misuse which may put person at risk. Also not knowing the area the person may become distressed or lost.

The provider was working within the principles of the MCA. Staff received training and had good understanding of the MCA. One staff member said, "Assume people have capacity. People can make their own decisions even if it seems odd to us. We can advise them but not make the decision. If someone doesn't have capacity we have to use least restrictive practice. We have multi-disciplinary meetings regularly to discuss decisions when a person lacks capacity."

We did see in some files where capacity assessments had not been recorded however, on the second day of inspection the registered manager provided us with these details from the local authority. We discussed this with the registered manager who agreed to ensure that all capacity assessments completed were in people's files so staff and others working with the person had access to this information.

One person living at Summerfield Court had a Court of protection document which included details of why the person was to remain at Summerfield Court and that due to their current vulnerability and lack of capacity a best interest decision was made that the person remain at the home to ensure there welfare and safety.

Consent was obtained both verbally and written were people had the capacity to do so. We saw care plans had been signed by people living in the home and people also told us they were asked for consent by staff. People's comments included, "Staff do come and tell me stuff" and "My keyworker goes through the care plan with me."

People were supported with their nutritional needs. People told us they cooked their own meals with the support of staff although the home also provided two options at lunch and dinner for people to choose from should they wish. People told us they were offered snack and drinks throughout the day.

Staff informed us nutritionists and dieticians were contacted should a person require further support with their dietary or fluid intake. For example, one person had a high risk of aspiration due to comprised swallowing (Dysphagia) and therefore staff supported the person to sit upright when eating to avoid choking. There was clear guidance for staff on how to ensure the correct thickener was added to each drink to reduce the level of choking for example, '4x scoops of resource thickener are to be used for every 200mls.'

Other health care professionals visited the home when there was a need and we saw this documented in daily notes. We saw district nurses involvement for people that required bowel management and catheter maintenance. Physio therapists, occupational therapists, speech and language therapists and people's general practitioners were also involved in peoples care planning. Each person's care file recorded individual health professionals involved in the persons care and minutes from multi-disciplinary meetings that took place with all health professionals to progress and monitor peoples care.

We also found the home actively encouraged people to remain healthy. For example, one person had a care plan in place to support the person to reduce the amount of cigarettes they smoked and staff encouraged other activities to divert the person from smoking high amounts of cigarettes in a short space of time.

Good

Is the service caring?

Our findings

People living in the home and staff told us they had positive relationships. People told us staff were their friends who helped to support them to become independent. People told us, "Staff are brilliant", "Staff are very good, couldn't ask for better" and "They are my best friends. They make you feel like we are part of a gang and best mates. They look as if they are not working, in a good way; we are all part of the same team."

Staff told us of their experiences to support people in their recovery to become independent and move back into the community. For example, one person who was unable to walk due to their physical disabilities' wished to walk down the aisle at their wedding. Staff arranged for the person to have physiotherapist input and accessed the homes gym to support the person to do this. The home also had an attached annex with flats for those people who were preparing to move into new accommodation and provided them with more independence.

We saw evidence which demonstrated people's diverse needs were being met. For example, one person wished to be cared for by female staff only and this was provided. Another person was supported to attend activities in the community which meant they could continue to be actively involved in cultural events.

Care plans ensured that when people were able they remained independent with their care. For example care plans stated, '[Name] can physically wash herself, however, if struggling she will ask for support where needed. [Name] will need support with drying and will direct the staff as to the level of support' and '[Name] strives to be as independent as possible and carries out their own laundry – staff should support [Name] especially with transferring the wet washing into the dryer or alternatively onto the washing line.'

People told us they were involved in all aspects of their care and that staff provided explanations about their care. Care files contained 'decision making profiles' which asked how people wished to be given information about their care for example, 'How does the person like to be given information about decisions. [Name] likes to be informed in a small group or on a one to one basis. Name needs to be informed verbally, with any information [Name] needs to remember, explained clearly and support staff to ensure [Name] has fully understood, by asking [Name] to recap what has been said. What ways can you help the person understand? Take time when explaining options to [Name], use simple non-complex language.' The document also asked about what time of day is the best to help the person make the decisions. This meant staff were openly involving people to ensure they understood their care and supported people to make their own decisions.

People's social history was documented in files and reasons as to why they have come to live at Summerfield Court. The historical information helped staff to build rapport with people, reminisce about their experiences and continue to support people to do things that they enjoyed to enhance their quality of life. For example, one person had a passion for music. For their birthday staff had arranged for the person to attend a concert which reflected their interests. We spoke to the person who told us they very much enjoyed this experience.

We saw that people living in the home were encouraged to remain in contact with their family, friends and loved ones. 'Relationship maps' were used to identify family members, support workers and friends that were involved with the person. We saw contact details and information about when people wished to contact their loved ones to ensure communicate remained.

People's privacy and dignity was respected by staff. People told us staff respected their privacy by knocking on doors before entering their rooms. One staff member told us, "If entering a room, knock let them know why you are there and explain what I'm doing, keep people informed of the situation."

Some people living in the home had an advocate. An advocate is a person who can support others to raise their views, if required. The registered manager told us that should anyone wish to have an advocate they used a local agency which people had access to.

End of life care was not provided by the home as people who lived there were assisted with their recovery and to move on to more independent living arrangements.

Good

Is the service responsive?

Our findings

Initial assessments had been completed by the provider or local authority to ensure people's needs could be met prior to them coming into the home and following this care plans were created. We found care plans had been updated regularly or changed to reflect people's needs.

Care plans were person centre as they included people's preferences, likes, dislikes and what was important to people as part of their recovery. For example, 'One page profiles' were used to identify people wishes, one stated, 'What is important to me… Having my own place, having a purpose and job, making friends, having some control over my life. How to support me well… Remind and encourage me to keep my goals, be positive around me, don't make decisions for me.'

One person had been supported with their recovery and as part of this staff assisted them to gain experience in areas they were interested in. For example, the care plan stated, '[Name] likes trainspotting; however he has expressed a wish to have a vocational placement or employment, doing "manual" work. [Name] has a work placement, which is manual and outside, both of which [Name] enjoys. [Name] is developing a programme of structured activities; [Name] is currently looking to develop these in the area where [Name] is proposed to be moving to.'

People were given choices about their care and how they wished to live their daily life. Care plans recorded this and examples included, '[Name] will usually request that her door remains open, however if she is watching television or waiting for the bathroom she will request that the door is shut – staff to ensure that they ask', '[Name] likes to sleep with her lamp turned off and her door closed' and '[Name] normally chooses to go to bed at around 20:30. Staff to support the evening routine and transfers to bed.'

People were encouraged to participate in activities and interests which they enjoyed. For example, one person went on holiday to America with their keyworker as they had a wish to visit Florida. One person enjoyed a particular band and staff supported them to attend a 'tribute act' concert. A walking group had been arranged by staff which supported people to visit a variety of places all over the country and to reduce social isolation.

One staff member told us that some people living in the home often found it difficult to remember due to their brain injuries, however pictures of activities helped them to reminisce and remember their experiences. We spoke with one person and saw pictures of their recent holiday on the wall and they spoke fondly about their experience.

People were also involved in activities which helped others in the community. For example, one person had been working with a youth offender's team to share their experiences of how they acquired their brain injury and how to discourage people from violence. The person told us they thoroughly enjoyed partaking in this experience and the registered manager said as a thank you to the person the youth offenders were planning to build a garden for growing vegetables.

We found where people had difficulties communicating the use of technology and accessible information was provided. For example, one person who had limited verbal communication skills used an 'app' on an Ipad which allowed them to communicate verbally with staff. Staff also told us they had used the Ipad to take pictures of the person completing daily activities so that in the future the person could inform staff what they wished to do by pointing at the pictures.

The provider had received one complaint over a 12 month period. We found this complaint had been managed effectively with actions taken to ensure this was resolved. The person who made the complaint was also asked if they were happy with the actions taken and had agreed that the issue was resolved. People living in the home told us they felt confident complaints would be managed, one person said, "Yes, I feel the complaint would be investigated."

We also found the provider had received compliments and kept a compliments book to document these. Some of these stated, '[Doctors Name] wrote to express his gratitude to [Staff name] who had accompanied one of the people on a hospital visit to St James. [Doctors Name] stated that [Staff name] had been very caring, considerate and empathetic to the person and very knowledgeable of the person's condition and [Doctors Name] said that [Staff name] was the best support worker they had met in the emergency ward' and '[Relative] wanted to pass on how grateful they were for the support [Staff name] had given their relative and herself and how supportive [Staff name] had been.'

Requires Improvement

Is the service well-led?

Our findings

The provider had quality and assurance systems in place however, these were not always effective. The provider had implemented quarterly, monthly and weekly audits within the home to ensure improvements were made. Some of these audits included, weekly bed rail checks, equipment such as hoists, slings and wheelchairs, window restrictors, fire checks and gym equipment. First aid checks were completed monthly and infection control checks quarterly.

Annual surveys had been completed to gather people's views. We saw the last survey was completed in August 2017 with overall positive comments which included questions and answers such as, 'What is the best thing about living at Summerfield Court? The best thing is I'm more independent now than I was before through all the support I have been given', 'How would you describe the care and support? Amazing, helpful, great' and 'Staff are caring and help me when I feel down.'

Although audits and surveys had been carried out we found in some instances actions had not always been recorded as completed. For example, three fire audits in January 2018 stated the number of the room were actions were needed however, the identified issues had not been recorded and there were no completion dates. One wheelchair audit identified that an arm of a wheelchair was loose although there was no record to show this had been rectified. We also looked at the audits for profiling beds and found one where a 'fault' had been recorded due to the lifting mechanism not working but found no action had been recorded to demonstrate that actions had been taken to address this.

We found the last annual survey did not have a fully completed action plan to follow up concerns raised by people in the survey. For example, we saw an action plan in place however; this had not recorded all of the concerns raised by people living in the home.

In addition to the above we also found records were not always kept within people's care files for staff and people to have access to. For example, we saw one care file that did not include the persons capacity assessment or details of their court of protection order. The registered manager showed us these documents and immediately added this into the persons care file.

We discussed our concerns with the registered manager and operations manager. The operations manager told us they used an "Atrium system" which monitored the work related issues highlighted from audits and actions taken. Although this was in place this was not reflected on the documentation on each audit outcome and by the second day of our inspection this had been implemented. The operations manager also confirmed that they would immediately implement an action plan to review comments people had made in the survey to ensure people's views were acknowledged and actions taken to improve the quality of care being provided.

We recommended the provider review all records to ensure they were accurate and up to date in line with best practice.

The manager had a clear understanding of their role and before the inspection we checked and found they had notified the CQC of certain important events as part of their registration.

Staff and people living in the home felt confident to speak with the registered manager, raise any concerns and said the manager was visible within the home on a daily basis. People appeared to know each other well including the registered manager and operations manager. People described the manager as, "Approachable" and "The managers have an open door policy; the manager will sit and listen to you. Over the last year the manager has changed the atmosphere, it's now very inclusive."

Monthly staff meetings and meetings with people living in the home took place to ensure their views were heard. People told us they discussed activities, celebrations, health and safety matters and any changes within the home to ensure people were informed about any new implementations.

The registered manager told us they were continuously looking at ways to improve and promote people's recovery within the home. The registered manager told us previously people stayed at the home for longer periods of time which did not always focus on recovery which is part of the homes ethos. The registered manager said in the last 12 months they have actively supported people's recovery, moved people into more independent living areas of the home and actively supported people to move into the community to improve their independence and quality of life.

The therapy co-ordinator told us about 'GAS' (Goal Attainment Scaling in Rehabilitation) goals which were used to help people achieve independence and progress in their daily lives. For example, we saw one person who had identified a goal to walk as previously spent the majority of time in their wheelchair. With the support from staff and a physiotherapist the person was monitored weekly on their abilities and was soon able to walk independently. The reasons documented for this goal stated, 'To support [Name]'s wishes to progress with walking phsyiotherapy. To reduce restrictions on daily living skills associated with being in a wheelchair.' This initiative had been positive and supported the person to improve their quality of life as they were now more independent.