Dimensions (UK) Limited

Dimensions 40 Cody Road

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?	Good

Summary of findings

Overall summary

The inspection took place on 22 and 23 March 2016 and was unannounced. Dimensions 40 Cody Road is registered to provide accommodation and support to five people. At the time of the inspection there were four people living there.

The service had a registered manager. 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.

The service is a large bungalow which accommodates up to five people with learning disabilities, physical disabilities or both. All rooms and facilities are on the ground floor and all areas are spacious, level and accessible to wheelchair users. The service has a garden on two sides, a driveway and parking for the service vehicle. The service has a registered manager who also manages two other services locally which are operated by the same provider.

People were kept safe because staff understood their responsibilities in protecting people and knew how to report any concerns. Staff put people first and were respectful in their interactions with people.

Risks to people were identified, assessed and measures were put in place to minimise risks. Staff were seen to carry out these measures.

There were enough staff at the service to ensure people's needs were met. We saw copies of the staff rota and noted that when there were times the staffing level was not sufficient, arrangements had been made to cover these gaps. The registered manager told us of the contingency arrangements in place to cover gaps in the staff rota, both planned and unexpected. These included staff working overtime shifts, the utilisation of staff from two other local services run by the registered manager or agency staff. We saw these arrangements were in place when we visited.

People's needs had been assessed before they moved into the service and were kept under regular review to ensure they were met. The service was well equipped to meet the varying needs of people using the service.

Effective recruitment procedures had been followed and the required checks on people applying to work at the service had been carried out. This helped the provider to ensure only those who were suitable to work with people were employed.

Staff told us they had received an induction into their role to ensure they understood people's needs and how to meet them. Staff understood the responsibilities of their role and the provider's values in supporting people to live the life they wished. We saw staff put people first during our visit.

Staff had completed training to ensure they had the skills and experience to support people effectively. This included training such as fire safety, first aid, safeguarding people at risk and moving and handling people for example. Other training to meet people's individual needs or newly identified needs had also been provided.

Staff told us they received regular supervision from their line manager in order to discuss their role, any development needs and any other aspect of working in the service they wished to discuss. Staff received supervision six times a year and an annual appraisal.

Medicines were managed safely to ensure people received their medicines as prescribed. Staff had been trained to administer medicines and people received their medicines in the way they preferred.

People using the service had varying methods of communication which were understood by staff, were clearly recorded and updated. Staff understood when people were giving their consent for support and when they were not. Staff understood the principles of the Mental Capacity Act 2005 and supported people to make their own decisions. Where people were unable to make specific decisions appropriate action had been taken in the person's best interest as legally required.

Where people's liberty was deprived, applications had been made to ensure that this was lawful and carried out in the least restrictive way.

People were supported to have enough to eat and drink and to maintain a balanced diet. Where additional guidance was needed this had been sought from appropriate healthcare professionals such as a dietician or a Speech and Language Therapist (SALT).

Support to maintain good health and to access healthcare services was provided to people as and when required. People were supported to prevent illness by having flu vaccinations for example. They were also supported to access healthcare services promptly if they developed an illness such as a cold. A number of healthcare professionals were involved in the support of people including a GP, dentist services, opticians and a chiropodist.

People were supported by caring staff who treated them with dignity and respect in a relaxed and friendly way. Staff knew each person well and were able to describe their individual needs. Staff involved people in the daily activities of the service such as cooking or cleaning their own room where possible and in decision making about their day to day lives. Advocacy services had been obtained when needed to support people's decision making.

Staff were aware of the need to provide people with privacy when they wished it and to provide support and care in a discreet way. Support plans were seen to provide clear guidance to staff about respecting people's privacy.

The service was responsive to people's needs. Staff recorded what worked well for people, what did not work so well and what could be learnt from things not working well. This was to ensure changes were made to improve the experience for people..

Although people were not able to complain in a direct, verbal manner, they were able to make their feelings known. Staff understood each person's ways of communicating and what that meant. One person would let staff know that they did not want to do something by pushing themselves away from the person or meal for example. Another person would communicate to staff that they had enough to eat by closing their

mouth firmly.

People were provided with an opportunity to give their views about the service each year in an annual survey, which was completed with the support of their relatives or staff.

The service was well-led and had a clear management and staffing structure. This consisted of a registered manager, deputy manager, a team leader and a team of support staff.

The registered manager and staff promoted an open, person centred service with a focus on putting people first. Accidents and incidents were reported and managed appropriately in order to prevent them reoccurring and to promote people's safety.

The quality of the service provided was kept under review and was monitored by the registered manager and the provider.

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 protected from harm because staff understood their role in keeping people safe.

Risks to people were identified, assessed and actions were taken to protect people from those risks. Staff were taking action to keep people safe.

Arrangements were in place to cover planned and unexpected gaps in the staffing rota to ensure sufficient staff were available to meet people's needs.

People were supported to receive their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained and had the knowledge and skills to meet people's needs.

Staff understood people's communication methods and used those methods to seek people's consent. People's rights were promoted and protected in line with legal requirements.

People were supported to have enough to eat and drink and to maintain a balanced diet.

People were supported to maintain good health and to have access to a range of healthcare services.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a relaxed and friendly manner and people responded showing they were at ease with staff.

People were provided with opportunities to express their views

through house meetings, reviews and satisfaction surveys. Where needed, advocates had been available to support people's decision making.

People's privacy and dignity were promoted and respected by staff when they provided people with care or support.

Is the service responsive?

Good

The service was responsive.

People's needs were kept under review to ensure the service could always meet their needs.

People were supported to maintain contact with people that were important to them and to access the wider community.

People's experiences, concerns and wishes were listened to which enabled staff to use these in order to support people.

Is the service well-led?

Good

The service was well-led.

The registered manager and staff team supported people in a way that was person centred and promoted the inclusion of people.

A clear management structure was in place to ensure people and staff were supported at all times.. People and staff had access to the management team who were visible and available in the service.

The service was kept under review to ensure that it provided quality care and action was taken to improve the service if needed.

Dimensions 40 Cody Road

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 checked 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.

The inspection took place on 22 and 23 March 2016 and was unannounced. When planning the inspection we took account of the size of the service and that some people at the service may find unknown visitors unsettling. As a result the inspection was carried out by one inspector.

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. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we interacted with all four people. Due to their differing communication methods people were not able to give us direct, verbal feedback or speak with us about their experiences of life at the service. Therefore we spent time observing staff interactions with them, and the care and support that people received. We spoke with four care staff, a team leader, the registered manager and the operations director.

We reviewed records which included two people's care plans, two staff recruitment and supervision records. We also saw records relating to the management of the service such as medicines records and quality monitoring documents.

Following the inspection we spoke with four relatives and two professionals who visit the service. We obtained their feedback about their experience of the service.

The service was last inspected in October 2013 and no concerns were identified.

Good

Is the service safe?

Our findings

We spoke with relatives of people using the service and they told us they felt people were safe. One relative said that people not being safe "had never crossed my mind" and another relative said they thought people were "very safe".

Staff members understood what safeguarding was, how to recognise signs which may indicate abuse and their role and responsibilities to ensure people were safeguarded from harm. Staff told us they were encouraged to report any concerns they had about people's safety. Staff knew who to report any concerns to and where they could access relevant information. Staff were aware they could escalate concerns outside of the service if needed, to head office staff for example.

Staff said they ensured that any marks on people's skin such as a bruise for example had been recorded in people's daily support records which we saw. This ensured there was a clear record and date of any injuries that were noted to people's skin so that this could be monitored and in the event that records were required.

The provider had a safeguarding policy which provided staff with guidance in relation to what might constitute abuse and the actions they should take. This was available on the provider's computer system which staff said they could access for guidance at any time.

People's records demonstrated that risks to them had been assessed. Where risks had been identified people had a support plan in place to manage the identified risks. Staff understood people's individual risks and were able to describe how these were managed to ensure their safety. For example, staff were aware of who was likely to display unsettled behaviours, how this may impact on others and what action to take to help the person.

The risks to people associated with moving them such as from their bed to a chair had been assessed. People's support plans reflected how many staff were required to move them safely. There were hoists available to transfer people safely including a ceiling hoist in the bathroom. We saw from records that staff had been trained in moving and handling people safely.

If it was identified people required specialist equipment this had been provided. For example two people had electrically adjustable beds that ensured the height could be adjusted for their safety and comfort. A specially adapted shower chair had been obtained for one person to meet their specific needs.

Staff had undergone the required recruitment checks as part of their application process. These included the provision of suitable references, full employment histories, proof of identity and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These checks helped the provider to ensure only those who were suitable to work with people were employed.

Staff told us that two staff members had left the service recently and the provider was recruiting new staff into those roles.

Staff said that there were usually three staff on duty for the early shift – 7.30 am – 3pm and the late shift – 2.30pm – 10pm, one staff member on waking night duty and one staff member sleeping in. This was based on providing support to five people living in the service. Since there had been only four people living at the service, we saw from the staff rota that there had been occasions when two staff had been on duty. Staff told us there were enough staff to meet people's needs and to keep people safe.

The provider's operations director & registered manager told us of the contingency arrangements for covering vacant shifts both planned and unexpected. These were covered by existing staff on overtime shifts, bank staff or by using staff from other local services under the same registered manager. Agency staff had also been used and were seen working in the service during our visit where other methods of covering shifts had not been successful. The registered manager told us they usually requested the same agency staff to work for a number of consecutive shifts to ensure consistency of support for people. During our visit we saw that staff had time to spend with people in a way that was not rushed and people could take part in spontaneous activities if they wished.

Staff told us that the deputy manager usually worked in the service in a management capacity but would take a care staff role if needed in the unexpected absence of staff due to sickness for example.

People's medicines were managed safely. People had medicine administration care plans in place to provide clear guidance to staff about what medicines people had been prescribed, what they were for, any likely side effects and how the person liked to take their medicines. We saw these had been signed or dated by the person checking in the receipt of medicines and by those who administered them. People had protocols in place for medicines they took 'As required' (PRN). There was clear written guidance for staff to follow to ensure the safe administration of people's medicines.

People's medicine administration records (MARs) had been fully completed and we saw this when we reviewed them in relation to two people. Staff told us that many medicines arrived from the pharmacy in "blister packs" which were colour coded for the time of day for administration and each held a 28 day supply of the medicine. Different medicines were supplied in individual blister packs and the system made it easier to check that medicines had been administered and to notice any omissions. Staff told us that people's medicines that were supplied in boxes and not in blister packs were checked each time they were administered to monitor the correct amount remained present. A weekly audit of medicines was also carried out and we saw a record of recent weekly medicine audits. The audit monitored for example that MAR charts were error free, any errors were appropriately reported / managed and all medicines were within their expiry date.

There was an accurate audit of the medicine held in stock. When new medicines arrived for people, staff ensured that any old stock was returned to the pharmacy. On the few occasions when medicines were carried over this had been recorded on the MAR to ensure there was an accurate record of the medicines held.

People's medicines were stored securely. Where people had homely remedies which are products that can be bought "over the counter", these had been authorised by the person's GP to ensure they would not counteract any prescribed medicines.

Where people had been prescribed ointments, lotions or creams for example, these were stored separately,

securely and the MAR charts had been completed when these had been applied.

Staff told us that medicines were always administered by two staff – one member of staff to administer and record the medicine and the other member of staff to witness these actions. We saw this process in action during our visit. This was to safeguard people from receiving medicines in error. Records showed that both staff were required to sign to show they had administered or witnessed the medicines given to the person.

People received medicines in the way they preferred such as on a spoon or with a specific drink and were supported with their medicines individually at the prescribed time rather than on a specific "medicine round".

Good

Is the service effective?

Our findings

Relatives of people using the service told us that staff had a good understanding of people's communication methods and how to interpret these. A relative gave the example of a person being taken out in the service vehicle who clearly indicated to staff that they did not wish to go out on that occasion. Staff acknowledged the person's preference and returned into the service.

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 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.

Appropriate applications had been made to the local authority for Deprivation of Liberty Safeguards (DoLs) assessments for each person to ensure that any limitations on their freedom were authorised and made in the least restrictive way.

People's rights under the MCA were upheld. Staff told us that people were assumed to have capacity to make their own decisions unless they were assessed as not having capacity. People were supported in this by offering a small range of choices and giving people time to make their own selection. Staff also respected people's choices such as what they wanted to wear, what they would like to eat or what activities the person would like to take part in.

Where a person did not have the capacity to make a decision affecting where they should live, we saw a record that a best interest meeting had been held. This had been held because the person had not been able to fully understand the options available to them or the implications of these. The best interest meeting had considered other available options and gave a rationale as to why the decision that was reached had been made. To support the person an independent advocate was involved along with other people such as a care manager in order to make a decision that was in the best interest of the person concerned.

Staff were aware of the requirements of the MCA and had discussed the MCA 2005 and DoLs at their staff meeting on 10 February 2016. The staff training record showed that all staff working in the service had completed MCA/DoLs training.

We saw that staff sought people's acknowledgement of consent before providing support, for example by asking people if they would like to have a drink or go out for a walk. Staff understood each person's communication method and knew whether the response was in agreement or not. The service followed legal requirements in relation to obtaining people's consent.

Staff told us they had received an induction into their role to ensure they understood people's needs and how to meet them, understood the responsibilities of their role and the provider's values.

The registered manager told us staff who were new to the caring role were required to undertake the Care Certificate. This sets out learning outcomes, competences and standards of care that care workers are nationally expected to achieve to ensure they understood the requirements of their role. A recently recruited member of staff confirmed they had undertaken that training.

Staff told us they received regular supervision in order to discuss their role, any development needs and any other matters relating to working at the service they wished to discuss.

Records demonstrated staff were receiving regular supervision as required by the provider's policy which stated supervision should take place six times per year to include an annual appraisal. Records demonstrated staff had received an annual appraisal of their work to enable them to reflect upon their practice across the year.

People were supported by staff who had completed training to meet their needs. Staff said they were adequately supported in their work and told us they had received lots of training. Records of staff training demonstrated that staff had received a range of required mandatory training to enable them to carry out their roles such as first aid, safeguarding people at risk, fire safety and moving and handling of people.

To support their development, staff told us they had been supported to undertake professional qualifications such as the Intermediate Diploma in Health and Social Care. We saw this was included in the staff training record.

People received the food and drinks that they preferred and were supported to ensure their nutritional needs were met. We sat with people while they were having their evening meal and it was clearly enjoyed by all. Staff told us they took it in turns to cook for people and that staff were aware of people's likes and dislikes. For example one person usually had the same cereal for breakfast but staff offered a choice in case the person did not want what they usually had.

Drinks were freely available, were offered to people throughout the day and people were supported by staff to remain hydrated. One person had their own cup to support them to have their drinks independently.

People had nutrition care plans that provided staff with guidance about whether the person could eat independently or required support, whether they had any food allergies or required a special diet. During the evening meal people who required support to eat their meal were assisted by staff. People who were able to eat independently were encouraged to do so and one person had an adapted plate which enabled them to do this. Where required people's meals were pureed or they were helped to cut the meal into small pieces to reduce the risks of choking. Staff also ate with people which promoted family style dining and supported people who may be at risk of choking.

People who had difficulties with swallowing, eating or choking had been referred to the Speech and Language Therapist (SALT) team and we saw a record of this in one person's support plan. Staff told us that another person had been referred to the SALT team and an appointment was awaited.

People were supported to maintain good health and to access healthcare services as and when required. People's records demonstrated that when staff observed a change in the person that indicated they required assessment by a healthcare professional such as a dietician this had been arranged. People had

been supported to see a range of healthcare professionals such as GP's, community nurses, physiotherapists, chiropodists, podiatrists, speech and language therapist, dentists and opticians for example. The service had their own transport and people had been supported by staff to attend appointments.

People had been weighed regularly and any risks associated with nutrition had been assessed and acted on. The assessment tool was used to identify people who may be at risk from either malnourishment or being overweight. One person's support plan referred to encouraging them to eat healthily to maintain their weight. The plan also recorded the person was to be referred to a dietician as the healthy eating plan had not been fully successful.

Good

Is the service caring?

Our findings

We were told by relatives that people using the service were well cared for and had a good quality of life. One relative said they felt this was apparent from the long period some people had lived at the service.

We saw staff were kind, caring and supportive to people and people responded well to the staff. People smiled at staff, or laughed and displayed positive body language which indicated that they were at ease with staff.

People received support in a caring way that was sensitive to their needs. Staff spoke to people politely and gently. They did not rush people and gave them time to respond. Staff were seen to position themselves at the person's height when speaking with them and to sit beside them when helping people with their meal. Staff assisted people to eat their evening meal and chatted with them as the meal progressed. Staff were heard to provide people with encouragement and with reassurance that they did not have to eat what they did not want.

We saw that people's support plans reflected how they wanted their support provided and staff involved people in decisions which affected them. A person's care plan reflected that they liked to be shown their towels and flannel by staff to let them know they were being offered a bath. Another person's support plan stated they preferred to have a warm drink before their shower and liked to have music played and this was provided. Records confirmed these preferences were accommodated and people were supported in the way that they wished.

People's rooms had been personalised to their taste. People were seen to spend their time where they wished either in the communal areas or in their rooms. Seating was available in the lounge, in the centre of the entrance hall and at the far end of the hall to provide people with a choice as to where to spend their time.

Records documented people's communication needs and how staff should ensure these were met. The records explained what people's different actions meant, what they needed staff to do for them and how the person could be helped. One person liked to go out for regular local walks for example and they would stand near the door to indicate this to staff. We saw this happen during our visit and staff responded by taking the person out.

To ensure people's communication methods would be understood by others such as hospital staff if needed, communication passports had been drawn up to provide specific guidance about communicating with the person. These described the "Things you must know about me", how best to provide information to the person and what their responses would indicate. For instance if one person continued doing what they were doing this would indicate they had not understood.

We saw that staff upheld the privacy and dignity of people when providing support or care. One person was supported to change their clothing and staff accompanied them to the privacy of the bathroom in order to

do this. Another person was supported discreetly to use the bathroom.
People's support plans provided clear guidance to each person's needs regarding their privacy, how staff should meet these needs and to respect people's times of privacy.

Good

Is the service responsive?

Our findings

Relatives told us that the service was responsive to people's needs. When a person using the service required a new wheelchair for example this was arranged. Relatives confirmed they were aware that they could raise concerns at any time if they wished and felt confident the service would respond appropriately.

It was clear that staff understood peoples' support needs and were responsive to them. When a person indicated that they wanted to go out for a walk, staff explained what was needed to get ready, helped the person to prepare at their own pace and then went out locally with the person.

Staff told us that one person had moved into the service recently and staff were gradually getting to know them, their personal history and the way they liked to be supported. The person's support plan had been drawn up based on the information provided by the person's previous home. Staff told us the information the person had moved in with was rather basic and they were gradually adding more information to the plan as they got to know their likes, preferences and dislikes. For instance staff had noted the person could manage one of their activities alone which staff had not previously been aware of. The person's goals and dreams for the future had been included in their support plan along with the support that would be needed to achieve these such as appropriate funding.

People's support was planned and provided in the way they preferred. We saw that support and other plans for a person who had lived at the service for a much longer period were very detailed. These included how they preferred their support to be provided, their likes and dislikes and how they made these known.

We saw that there were resident's house meetings and notes were taken of the discussions. A monthly newsletter had been produced and was displayed in the main corridor of the service. This explained different events that had taken place during the month and what each member of the service had been involved in. The January newsletter for example referred to celebrating St Valentine's day and St Patrick's day in February. Staff told us that although people using the service were unable to read the newsletter themselves, it was displayed so that relatives and visitors could refer to it and talk to people about the events.

Peoples' independence was promoted. If people required adapted plates or cups for example, to enable them to eat their meal themselves staff had ensured these were provided. One person was able to walk around the service but needed to use a wheelchair for longer distances and this had been made available.

Staff understood people's support and care needs and were aware of the importance of ensuring the service was suitable to meet people's needs. Staff knew who required a greater level of support or supervision and were able to describe people's individual care needs. Shift handover meetings between staff were used to update staff coming on duty to any changes in people's needs, health or medicines for example. Staff told us they also used a communication book to advise other staff of information they needed to be aware of as well as recording changes or events in people's support plans or other records. We saw the communication book in use during our visit.

Staff were observed to engage people in activities which might interest them including the use of the sensory room which had facilities for music, multiple, pattered lights and large floor cushions for people to relax on. People were supported by staff on a one to one basis and staff were aware of ways to calm people when something needed to happen that they were not keen on. For example one person was having their fingernails trimmed in the sensory room while music that they liked was being played and the colourful lights were on. This ensured they were relaxed and distracted from the nail trimming. People were well presented and were supported with personal hygiene and to change their clothes at any time if required.

People were supported to take part in wider community activities including visits to coffee shops, garden centres, shopping for personal items and attending a local day centre. The service had its own minibus which was equipped to transport people in a wheelchair if needed. Staff told us there was currently only one member of staff qualified to drive the service minibus but the registered manager told us of the steps they had taken to provide additional transport support. For instance they had requested an agency member of staff who was able to drive the bus to enable them to support people in going out as frequently as they would like. The ability to drive was also a key condition for any prospective new staff applying to work at the service. Occasionally people using the service would go out to events with people from another local service in their minibus if a driver was not available at this service.

Although people were not able to make a direct, verbal complaint, staff were able to describe to us the ways in which people would indicate they were unhappy or did not want to do something. It was clear at the evening meal time that people could make their wishes known and staff respected these. One person indicated by their actions that someone was sitting too close to them. The person relaxed and continued with their meal once the other person had moved away.

One person for example would push themselves away from the table or from people if they were unhappy about something. They were also able to use a number of facial expressions or other actions to convey their feelings

The service had a procedure for making a complaint or speaking out. We saw that a version of the procedure in an accessible format was included in people's support plans.

Good

Is the service well-led?

Our findings

Relatives told us the registered manager was accessible to them by telephone or when they visited the service and they would happily raise any questions or concerns about people using the service.

There was an open, family orientated atmosphere at the service. Staff told us the provider's values were to support people to live their lives in the way they wished and it was clear that staff understood their role in supporting people to achieve this. For example, staff respected that they were working in the home of those living there and put people's needs and choices first.

We saw that staff were very involved in the service and there were regular staff meetings, the notes of which were recorded for staff who were not able to attend. We were provided with copies of the notes from recent staff meetings. Staff were aware of the provider's whistle-blowing policy and how to access that should they have any concerns.

Staff told us they felt well supported by the management team. Staff commented "You can go to them with anything" and "She (the registered manager) is here for the people and the staff; she wants the best for them and makes it a home." Staff told us the provider's head office were also accessible and supportive. The provider's operations director visited the service regularly and came to the service on the first day of our two visits. It was clear that people and staff were known to the operations director and people were at ease with them.

To ensure the service was well-led, the operations director explained the management structure for the service, as in addition to this service, the registered manager also managed two other services locally. They said the registered manager was supported by a deputy manager who also worked across the three services. Each of the three services had a team leader and a team of support staff. These management arrangements were working effectively as staff said they had regular access to the registered manager and the deputy manager. In addition staff told us there was a management on-call system to ensure staff and people were always fully supported. We saw the details on the people who could be contacted by staff displayed in the service office.

The provider used a number of methods to ensure the quality of the service provided such as surveys for people and for staff and audits. Staff told us that the quality of the service was monitored by the provider and by the registered manager. We were supplied with copies of the provider's Compliance Self-Assessment template which was scheduled to be carried out four times each year.

This had been used by the registered manager and the provider's compliance auditor to assess various aspects of the service. We saw it included fire safety, first aid, infection control, the safety of the service vehicle and a review of aspects of health and safety and equipment. The registered manager told us the service was scored for each area on the self-assessment template and a comment would be recorded if required stating what had been done, when it had been done or what needed to be done. The score was used to create a red, amber or green rating and the rating would be used to indicate the urgency of any

action that was required. The compliance assessment recorded that in response to feedback from this self-assessment the kitchen had recently been refurbished for example which staff had already told us about. The kitchen dining room presented as a bright and clean area for people to enjoy preparing and eating their meals.

A service improvement plan was also used to ensure action was taken for the benefit of people using the service, to improve the service or to maintain safety. For example, a new bed was needed by a person using the service and this was included on the improvement plan, along with how this need would be met, who would be responsible and the target date for completion. This was marked as completed and the person's new bed was in use at the service.

The provider supplied people with an annual survey to assess their views about the service and a completed example was seen. Where needed, people had been assisted by relatives or staff to reflect their views. The registered manager said the results of the survey were returned to the provider's head office and reviewed for any action required but no examples were available.

Staff were also provided with an opportunity each year to give their views about the service. The registered manager told us that a change had been made to the online learning provided to staff in response to staff comments. A new on line system was due to be launched in spring or summer 2016.

To promote people's safety and prevent accidents and incidents reoccurring, these were reported and managed appropriately. A computer based system of reporting & checking accidents and incidents was in place. This had been established by the provider to include a number of different levels of checks to ensure that appropriate action had been taken if needed. The system was shown to us and we saw that the registered manager had made an entry to record the action taken following a recent event.

The supplying pharmacist audited the medicines in the service in 2015 and found no issues were identified. The team leader told us they completed a weekly audit of the medicines and this was last completed in March 2016. We saw the record of the weekly audit of medicines from March which showed actions had been taken. For example one person's medicines that were no longer required had been returned to the pharmacy.

Records were well managed and organised to support people using the service and the operation of the service. People's records demonstrated they were receiving the support described in their personal support plan. From reviewing the plans it was clear how people preferred to be supported, what they liked or did not like and how they indicated this.

Staff made daily diary records of the activities of each person. These included what had worked well, what had not worked so well and why, what could be learned to improve the support or service for the person. Separate pages in the diary were used to record what meals people had, their general health matters and people's contact with others for example.

Systems were in place to protect people's confidential information. People's records were stored securely and were only made available to those authorised to view them.

Records relating to people or the service were readily accessible within the service. Some records were stored electronically on the provider's computer system but these were made available as required and copies were supplied for reference.

Risks to people had been recorded although one did not specify that a person should not be left alone when eating because of a choking risk. Staff told us that people were never left alone when eating or drinking and we saw that this was the case during our visit. The provider's operations director told us that would be updated and that the risk system in use by the provider was being reviewed to make it more effective.