Dimensions (UK) Limited

Dimensions 82-84 Booth Road

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 7 and 20 September 2016 and was unannounced. The service met all of the regulations we inspected against at our last inspection in September 2013.

Dimensions 82-84 Booth Road is a care home for up to eight adults. There was one vacancy when we inspected. The service specialises in providing support to people who have a learning disability or who are on the autistic spectrum. Autism is a lifelong condition that affects how a person communicates with and relates to other people, and how they experience the world around them.

There was a registered manager in post at the service. A registered manager is a person who has registered with the 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 and their representatives provided good overall feedback about the service. We found that the service was working hard to improve people's quality of life. For example, people received good support to go out lots. There were ongoing efforts to find activities that people liked. Some people had been on holiday, in line with agreed personal goals and the provider's current business plan.

Staff worked well together and came across as motivated to provide people with good support. People were treated in a respectful and friendly manner. They were encouraged to maintain and develop skills and independence, and were supported with relationships that were important to them.

People were provided with support to maintain good health and nutrition. The advice of appropriate healthcare professionals was sought and followed where needed. People's individual needs and preferences were kept under review. Action was taken to address individual risks to people using the service, and safeguarding procedures were properly used to help keep people safe.

There was a positive and empowering culture at the service. The registered manager and the provider demonstrated good management and leadership. The quality of the service was audited and action was taken where improvements were needed, including in response to our feedback. This all helped to assure that high quality care was being provided.

However, the service was not consistently safe. Whilst enough staff were working at all times, there were avoidable safety risks to people using the service arising from some staff working long hours across consecutive days. Systems had not ensured that appropriate written references were always obtained for new staff. Whilst people received their medicines as prescribed, a number of people's as-needed medicines lacked specific guidance around offering it to them.

We made one recommendation in this report based on an area for development identified at this

inspection. This was around developing staff skills in respect of recognising and responding to people's individual communications.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Whilst enough staff were working at all times, there were avoidable safety risks to people using the service arising from some staff working long hours across consecutive days.

Whilst people received their medicines as prescribed, a number of people's as-needed medicines lacked specific guidance around offering it to them.

Systems did not ensure that appropriate written references were always obtained for new staff.

However, action was taken to address individual risks to people using the service, and safeguarding procedures were properly used to help keep people safe.

Is the service effective?

Good

The service was effective. People were provided with support to maintain good health and nutrition. The advice of appropriate healthcare professionals was sought and followed where needed.

Staff received support and training that equipped them to support and meet people's needs, although this needed completion in a few service-specific areas.

The service was working within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People were treated in a respectful and friendly manner. The service supported people to attend to their appearance and keep clean.

The service encouraged people to maintain and develop skills and independence. People were supported to have a community presence and maintain or develop relationships.

We made a recommendation around developing staff skills in

respect of recognising and responding to people's individual communications.

Is the service responsive?

Good

The service was responsive. People's individual needs and preferences were kept under review and acted on. There were reasonable procedures in place to listen to and address concerns and complaints.

There were ongoing efforts to find activities, in the service and in the community, that people liked. Some people had been on holiday, in line with agreed personal goals.

Is the service well-led?

Good

The service was well-led. There was a positive and empowering culture at the service. The registered manager and the provider demonstrated good management and leadership. Staff worked well together and came across as motivated to provide people with good support.

There were a number of ways in which the quality of the service was audited and scrutinised. Action was taken where improvements were needed. This all helped to assure that high quality care was being provided.

Dimensions 82-84 Booth 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 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 inspection took place on 7 and 20 September 2016 and was unannounced. The inspection was conducted by one inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service including notifications received. A notification is information about important events relating to the care provided which the service is required to send to us by law. We also checked the 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 planned to make.

During the inspection, we were unable to acquire much feedback about the quality of the service directly from people using the service due to most people having complex communication needs that we could not understand and gain views from. We used other methods to help us understand the experiences of people using the service. We spent time observing care in the communal areas such as the lounge and kitchen areas, and we looked around the premises.

We spoke with three relatives by phone, six care staff, an assistant manager, the visiting quality and compliance auditor, and the registered manager. We looked at three people's care and medicines records, three staff files and training records, and various records kept for the management of the service including staff duty rotas, accident and incident records, and quality assurance records.

Between the inspection visits we received feedback from an involved healthcare professional. The registered manager also supplied us with copies of further documents such as policies on request.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us the service was safe. One relative told us, "They scrutinise the staff." We found that checks took place of prospective staff before they worked in the service. Records showed that, following a written application, there was an interview by two senior staff members along with consideration of written ability. Checks also included a Disclosure and Barring Service (DBS) disclosure, identity documents, and right to work in the UK. However, of the three newer staff who we checked on, in one case there was no written reference in place from the previous care employer and no records to show that all reasonable efforts had been made to obtain one. There was a verbal reference on file instead, however, it was from an employee of that employer, not the employer and so may not have provided all relevant information. This did not show that safe recruitment practices had been consistently followed in that instance. However, we noted that the provider had updated their recruitment policy since then, which would prevent a reoccurrence of the same issue.

The registered manager told us of ongoing recruitment, but that selectivity was necessary to ensure that only staff with the right values worked at the service. This was checked at interview, and then through a visit to the service to meet people and see how the applicant interacted. The views of people using the service were also obtained as far as possible.

The registered manager told us that the provider required staff to renew their DBS checks every three year, to help reassure that they remained suitable to work with people using the service. We saw records confirming this practice.

The premises had been adapted to promote safety. For example, there were window restrictors in use in upstairs rooms, radiators were covered to prevent scalding, and many doors were fitted with devices to prevent anyone trapping their fingers between the door and the frame. Fire evacuation procedures were prominently displayed. There were records of regular fire safety checks that were backed by fire safety risk assessments undertaken by competent professionals. Equipment was regularly serviced and maintained. The registered manager showed us that, in-between our visits, the service had been awarded a five-star rating, the highest possible, from the local food standards agency in respect of food safety and hygiene. This improved on the four-star rating from three years previous.

There were many ways in which the service attended to people's identified safety needs. One person was at risk from putting inappropriate items in their mouth (known as PICA behaviour). There were guidelines easily available for staff on how to support the person safely in respect of this risk. Staff we spoke with, including agency staff working with the person, were aware of these responsibilities. People had individual fire evacuation protocols, which staff told us they had read and signed. There were adapted baths and a walk-in shower room, which enabled people to bathe more easily and safely. An instructional poster in a bathroom explained how one person needed to be helped to use the toilet safely.

The service carried out risk assessments that enabled people to take acceptable risks as safely as possible. This included activities at home, within the community and when on holiday. There were also health related

risk assessments for areas such as nutrition and choking. The risks assessments were monitored, reviewed and adjusted as people's needs changed. There were also general risk assessments for the service and equipment used that were reviewed and updated.

We saw that chemicals were locked away within the laundry area. However, most bathrooms had some household chemicals within unsecured cupboards, and in one case, some descaling liquid behind a bath. There were a number of risk assessments about the use of different household chemicals. For descaling chemicals, the assessment stated for secure storage. The provider's policy of the control of substances that are hazardous to health (COSHH) confirmed that cleaning materials were to be stored in locked cupboards. This risk to people's safety was not adequately addressed at the time of our first visit, although it had been addressed by our second visit.

The service had systems in place to protect people from the risk of abuse. Notifications from the registered manager showed that allegations of abuse were reported to the local authority as required, and were investigated. Action was taken to minimise the risk of reoccurrence, including staff disciplinary processes where appropriate. Whilst older notifications indicated that delays occurred in reporting potential abuse to the registered manager and then to us, recent notifications showed that these matters were resolved. The registered manager told us that safeguarding processes were discussed in team meetings so that staff were clear on their duties. Minutes of meetings confirmed this. There were posters on display in the office advising staff of how to raise concerns about poor practice (whistle-blowing), and the procedure was included in the record of what to cover with new staff.

People's medicines were safely and securely handled. Staff were trained on administering medicines to people, and records showed that their competency was regularly reassessed. There was guidance for each person's medicines including how they preferred to receive medicines support.

People's medicine records were fully completed and up-to-date. Two staff signed for each administration, which helped minimise the risk of errors. We found no discrepancies between medicines records and remaining stock, indicating that people received their medicines as prescribed. Staff showed us weekly recorded checks of all medicines, and ongoing stock records for separately-boxed medicines, to help ensure this.

However, individualised guidelines were not always available for each person's as-needed medicines. Whilst staff could explain how they individually made decisions on when to offer as-needed medicines based on their knowledge of the person, some as-needed medicines had little recorded to help ensure that all staff were consistent in how the medicine was offered. The provider had designated guidance forms for as-needed medicines that had been filled out in a few cases. However, for the three people we checked on, there were five as-needed medicines that did not have specific guidance. The registered manager agreed to address this. She also showed us a pain-management profile that had just been set up for one person and planned for others, which helped clarify as-needed pain management guidance.

The registered manager and staff told us that there were usually five staff working until mid-afternoon, then four for the rest of the day. There was one staff member working overnight along with one staff member sleeping at the premises but available in an emergency. Additionally, a sixth member of staff was funded to work six hours daily with one person using the service, which we saw highlighted on the staffing roster. The registered manager told us of ongoing recruitment so that only staff with user-empowering values worked there. There were hence staffing vacancies which were filled by using the same small team of agency staff.

Most staff told us there were enough staff working at the service, but one commented that whilst one person

had just started receiving additional funding for one-to-one care in the morning, it was not enough as the person needed it in the afternoon too. The staffing roster indicated that staff sometimes worked long hours. For example, during the week before our first visit, four staff worked across the whole day on two consecutive days. One of them was the staff member who slept at the service during the night and hence was available for emergencies if needed. This put staff at risk of being tired, which could undermine their competency towards the end of their shifts. We noted that one of the staff involved in a recent medicines error had completed three back-to-back shifts starting the previous morning. The registered manager conformed that there was no risk assessment relating to staff working long hours, but noted that no staff were required to work additional hours and there were other limits on additional hours worked. However, this did not assure us that staff providing care consistently had the competence to do so safely. This undermined the service's ability to ensure that there were sufficient numbers of suitable staff to keep people safe and meet their needs.

Good

Is the service effective?

Our findings

We received positive feedback about the effectiveness of the service. A relative said, "They take her to the doctors, they sort it out and keep me informed." A healthcare professional told us of the service working in cooperation with them.

People were provided with support to maintain good health. Records and staff feedback showed that people were supported with routine and as-needed healthcare appointments. For example, people had regular medicines reviews with their GP. Efforts were made to reduce the amount of medicine people were prescribed. We were told that no-one was prescribed or used as-needed medicines to help with anxiety or behaviours that challenged. Where one person was found to have a rash, prompt GP advice was sought to acquire a prescription treatment. There were also Hospital passports in place for people, to help inform hospital staff of relevant information about the person.

There were a number of guidelines available to help remind staff on specific health procedures for individuals, such as for chest care and safe eating support. One person had specific guidelines arising from the involvement of a community physiotherapist. There were regular records of following these guidelines. Where some equipment involved in the guidelines was recently malfunctioning, records showed that action was being taken to address the issue and so consolidate the effectiveness of the guidelines.

One person came out of hospital a few months before our visit. Guidelines were in place for supporting them with changed healthcare needs. The guidelines included for supporting them regularly with drinks. There was a fluid intake chart in place for them. However, it was not consistency filled in. The person's nutritional risk assessment stated that the chart was to be used to help avoid dehydration, which the registered manager confirmed as correct. We checked the person's care records which assured us that the person was receiving regular drinks. The concern was therefore with consistent record-keeping on a chart designed for that purpose. The registered manager sent us an action plan after the inspection that addressed this point.

Staff showed good knowledge of people's health issues and the support they needed for these. For example, one person had received professional input for weight gain. A staff member told us of different strategies being used to support them to eat less without restricting their access to food. We saw the person being encouraged and accepting healthy eating options in the kitchen, and that they were not restricted there. We checked the person's recent weight records and saw that there was a gradual weight reduction across the last few months, indicating that the strategies were working. Records showed that where another person had recently experienced unplanned weight loss, GP advice had been sought and the situation was being monitored.

People received sufficient support with nutrition and hydration. One person told us, "The food is nice." People were advised and supported by staff to be involved in meal preparation where possible. People's care plans had information on the type of support required at meal times. For example, one person had adapted equipment that enabled them to eat independently. Staff observed how much food was eaten and gently encouraged people to finish, with comments such as, "Have you tried the coleslaw?"

An agency staff member told us that the provider was "strict about training" and so they had to complete a course before they could work at the service despite being well qualified. Team meeting records confirmed this approach. The staff member told us their work involved gradually building up experience of working with an established staff member and a person using the service before working alone with them. The registered manager showed us detailed induction forms that new staff worked through at the service before working with people. This all indicated that the service made a lot of effort to ensure agency staff could meet people's needs and provide an effective service.

Records showed that staff received induction training that equipped them to support and meet people's needs in an effective way. The induction followed the national 'Care Certificate' standards across a 12-week period. New staff shadowed more experienced staff as part of their induction, to increase their knowledge of the service and people who lived there.

Staff received update training on a regular basis. Records demonstrated that this included safeguarding, infection control, medicine, food hygiene, and equality and diversity. The registered manager told us that this was mostly online training for which staff had to answer a set of questions to demonstrate understanding. Classroom-based training took place for emergency first aid and moving and handling. Hoist training and observation was undertaken at the service to ensure staff understood people's specific hoisting needs.

There were oversight records on all core training courses and on some service-specific training such as epilepsy. These showed that the staff team were up-to-date. The registered manager said that the provider's positive behaviour support team had recently given staff specific training on working with one person whose behaviour was challenging the service. There was evidence that this had helped improve the service for the person, including positive written feedback from the person's representatives.

However, during our visits we could not be shown any oversight records for which of the staff team had had received training on autism or dysphasia. Some people using the service had needs relating to these conditions. The registered manager told us that this training was ongoing, and we were shown examples of where more staff were booked for this. Following our visits, the registered manager sent us an audit of these trainings for the staff team. It confirmed that some staff had had received each training, and showed that any skills gaps were being addressed.

Records and staff feedback showed that supervisions and appraisals took place regularly and provided an opportunity to identify individual training and support needs.

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 so that they can 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 provider had appropriate policies in place and had produced guidance for staff on working in line with the MCA. Most people using the service

had a DoLS in place or awaiting approval. There were conditions attached to some of these safeguards which we saw were currently being met.

Staff had received training on the MCA and demonstrated understanding of MCA principles. A staff member said, "If someone refuses care, we try to convince them, reason with them. If someone refuses medication and we can't convince them, we call the GP. We've never had to force anyone." This reflected the approach we saw staff taking, that people had choice and control over decisions as far as possible. There were also no restrictions on accessing communal areas of the service. The registered manager noted that best interest decisions and meeting took place where appropriate, for example, to formally agree the holidays planned for some people. A meeting was being planned for another person in respect of a proposed healthcare procedure as the person could not consent to it and it was unclear if the outcomes outweighed the risks.

Good

Is the service caring?

Our findings

People were treated in a respectful and friendly manner. We saw staff and the registered manager paying attention to people and helping them where appropriate. For example, one person seemed agitated whilst trying to adjust their clothing. A staff member who was working with another person noticed and went over to them, and upon gaining consent helped them to get comfortable. People were warmly greeted when they returned from trips out and staff said goodbye to people before they finished their shifts and left the premises. Some people clearly showed that they liked the interactions, for example, through smiles and gestures. Treating people respectfully was considered during staff recruitment and the induction of new staff.

The service supported people to attend to their appearance and keep clean. Some people had dyed hair or painted nails. One person was supported to change their top in private when it could not be wiped cleaned. Attention was paid to cleanliness in people's rooms and we encountered no lingering odours in the service. Team meeting records reminded staff about the support individuals may need with appearance.

The service encouraged people to maintain and develop skills and independence. A staff member told us that people were encouraged to help where they could with meals, such as with putting potatoes into pots or with taking their laundry basket to the laundry room. If people could not help, they were encouraged to be present, for example by being in the kitchen when meals were being cooked. We saw people being supported to be as independent as possible, for example, with eating, laundry and watering plants. A staff member told us, "We allow the service user to make use of the skills and abilities they have."

People's choices were listened to and enabled where possible. Although most people were non-verbal, staff responded to their gestures respectfully. For example, one person moved their arm a little to indicate that they did not want a prescribed medicine at that moment. Although the person could not say what they wanted instead, staff offered the person a drink which they fully accepted before then agreeing to take the medicine. An instructional poster in one person's bedroom reminded staff on the procedure to follow to allow that person to choose their own clothes.

Staff told us that one person was asked which staff they wanted to work with, as they could understand the verbal choices and express a response. We saw this occurring. Before we spoke with this person, staff explained our presence and asked them if we could speak with them. The registered manager told us of some other people using the service who sometimes demonstrated that they did not want to work with specific staff at that time, which was respected.

One person was upset for a short period during our visit. They explained that they were expecting to go out but it had not yet occurred. Their comments included, "They shouldn't say they are going to take you out and then not do it," adding that the time they were told had changed from after lunch to later in the afternoon. Staff and the registered manager provided them with reassurance, and they were supported to go out later in the afternoon. The registered manager agreed that the messages provided to the person were not clear enough for them. On the second day of the inspection, the registered manager told us of providing

an alarm clock by which the person could be helped to understand when support they were looking forward to would be provided.

One staff member told us they were not sure how much people using the service understood, in respect of use of a pictorial menu planner. The registered manager told us that having enough pictures for the planner was work in progress, and hence the menu did not quite match the food served that day.

The registered manager told us of efforts to support one person with picture cards to help them make choices and understand proposed activities. However, feedback was that this was not necessarily working, and hence objects of reference were being considered.

We noted that people's care files included detailed individual communication profiles. It was therefore clear that effort had been made to understand people's different ways of communicating. We therefore concluded that, whilst staff had a willing approach to trying to understand people's communications, people did not consistently experience effective communication as the staff teams' overall skills were not sufficiently specialised towards recognising and supporting people's individual methods of communication.

We recommend that advice be sought from a specialist communication organisation so as to review people's individual communication abilities and set up programs for the development of staff in recognising and responding to these communications.

Some aspects of the environment showed good care and attention to people. People's bedrooms were well-decorated and individualised, making them welcoming. The registered manager told us that people and their families had been involved in choosing colours and, in one bedroom, a horse theme.

Aspects of the environment did not, however, consistently promote people's dignity. We saw that a number of windows, for example, in the kitchen, were 'blown' in-between the two layers, meaning they could not be looked out of easily. The edging was hanging loose off one side of a mobile table in one lounge. A staff member told us the only thing they would change about the service was aspects of the environment, although they felt it was a homely service as evidenced by there being more and more photos of people using the service on display.

The registered manager told us that the premises had an institutional layout and décor, and showed us records of attempting to address these matters. For example, although the building was owned by a housing association, the provider had paid for basic refurbishment in the last year. We were shown evidence of long-term planning considerations in this respect. This reassured us that the provider was looking to address environmental wear issues.

People were supported to have a community presence and maintain or develop relationships. The registered manager told us that one person had been supported to re-establish contact with a family member, with whom they now made regular phone calls and occasional visits. Another person was supported by the service to visit and receive visits from a family member. Someone who had moved into the service more recently was supported to attend a club they enjoyed on the other side of the borough.

One relative said, "The manager is available and phones up when needed." Records showed that family members were kept informed of key events in the lives of people using the service.

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs and preferences. Team meetings included consideration of each person's current situation and how staff could provide a better service based on that. There were specific guidelines in place for anyone where additional support was needed, such as for ensuring hydration or how to support someone with physiotherapy exercises. Where one person's recent withdrawn behaviour was causing concern, a referral to the provider's behaviour support team had been made.

Staff we spoke with demonstrated consistent knowledge of people's individual needs and preferences. For example, two staff independently told us that one person liked visiting a local restaurant where they could quickly help themselves from the salad bar as they did not like waiting for the main meal. We saw staff move seats at the table when one person came into the kitchen, saying to them, "oh [name], we've taken your chair, we'll move." The staff member explained that the person always liked to sit in one particular spot.

A staff member said, "The staff is diverse, which helps with the service users. We value their culture and gender using the support plan." Support plans we saw reflected this. The registered manager told us that monthly cultural celebrations were held in the service that coincided with religious festivals where possible. One person attended religious ceremonies regularly with the support of specific staff.

There were individual support plans for each person explaining specific care needs, what the aim was in respect of each need, and how staff would provide support. These covered, for example, personal care, health matters and mobility. It was backed by a person-centred plan that focussed on the preferences, skills, abilities and goals of the person, and by assessments of risk and the reduction of specific hazards relevant to the person's care and support. There were monthly progress reviews which varied in focus. Some reviewed the person's holistic progress, other focussed on progress in one specific area. This all helped to provide a responsive service to people relevant to their needs and abilities.

People had had review meetings within the last year at which they and other relevant people involved in their lives attended. Reports of the meetings, including from the local authority, indicated good overall standards of service. Goals were set at the meeting. Records and feedback showed that these were being attended to, for example, to pursue specific health checks and to undertake more activities.

A relative told us the activities provided were "fantastic." One person told us of activities they pursued including bingo, college and shopping. The registered manager told us of most of the house having a day out in Southend recently. One person in particular had enjoyed the opportunity to use the beach and the sea.

A staff member told us that they tried lots of different activities for people using the service as it was hard for most people to communicate what they did and did not like unless they experienced the activity. For example, one person had been supported to go to a resource centre where it became clear that they liked the sensory room on offer but not the reflexology they had signed up for. Another staff member told us that

the service had gained a large minibus from another of the provider's services. As there were a number of drivers within the staff team, this helped people to have better community presence at activities they liked. Team meeting records showed consideration of different activities in and out of the premises, which confirmed the ongoing efforts to find activities that people liked.

Staff and the registered manager told us and showed preparation for an imminent week's holiday in Portugal for two people using the service. The registered manager told us that this was a specialist facility that had, for example, hoists available to help people transfer. At our second day of inspection, we were told that one person had particularly enjoyed the holiday, swimming every day for example. There were now plans to support the person to go swimming locally. Another person told us they had been to Butlins this year. The registered manager added that people had not had holidays in recent years, and so this was an improvement in the quality of life for some people, in line with agreed goals for people.

There were reasonable procedures in place to listen to and address concerns and complaints. One person said, "The staff are good, they check on you, ask if things are ok. I say if something's wrong." A relative told us they would speak with their family member's key-worker if they had concerns. The provider's complaints policy and procedure was available to people living in the service and their representatives. There was one complaint recorded across the last 18 months that recognised and followed-up on concerns raised by a healthcare professional. At our second day of visiting, the registered manager explained actions taken to address one person's concern that the person told us of during our first visit.

Good

Is the service well-led?

Our findings

The feedback we received indicated that the service was well-led. For example, a healthcare professional told us of the management team at the service working effectively in the interests of people using the service.

Staff were motivated to provide people with good support and spoke positively about them. The registered manager told us of changes to the staff team across the last year but that the current staff team were focussed on meeting people's needs and enhancing their quality of life. In support of this, a second assistant manager post was temporarily in place. One staff member told us of there being more activities and community presence than in the past. Another said the service was "like a proper home" for people.

Staff told us the registered manager was approachable and empowered them. A staff member described the service as working transparently. They said, "The managers are very involved and there is good teamwork." Another staff member said that their ideas for improving services for people were listened to and tried out, and so they now felt more confident at making suggestions. We saw that the registered manager led by example, and that people using the service were comfortable in her presence. The registered manager told us that a strength of the service was that staff worked well together. Staff feedback and our observations confirmed this to be the case.

Staff meetings were held in support of maintaining a positive and empowering culture. The two most recent staff meetings indicated a six-weekly frequency. The meetings included guidance on safety standards, discussion on how staff demonstrated the provider's values towards people using the service, and consideration of the current needs of each person using the service.

The registered manager gave examples of where assertion was necessary. For example, a complaint was made about how a community healthcare professional had caused anxiety to someone using the service. Another person had been in hospital for a period and was being discharged without sufficient community support. The registered manager told us she had ensured that a best interests meeting first took place, so that sufficient support structures were established to meet the person's needs once back at the service.

The registered manager told us of ways in which the provider enabled good management and leadership. At a regional level, she was involved in manager learning sets that considered insights from the Commission's inspections of the provider's services and other services that attained the outstanding rating. She was attending a 'Working Together for Change' workshop that involved improving services for people regionally. Another group was for learning from significant safety incidents occurring in the provider's services. She also attended the local authority's Quality in Care Homes workgroups.

There were monthly provider bulletins displayed in the office about organisational developments and plans. A recent bulletin included details about events to gain views on the provider's services including what had and had not worked well for people using the service in the last year. This would help to inform the provider's ongoing objectives. Records and feedback from the registered manager showed that the provider

held regular events by which to listen to the views of people using the service and take action as a result of these. The views of people's representatives were also encouraged, such as through newsletters and surveys.

The provider sent customer satisfaction surveys to everyone using the service and their representatives at the end of 2015. Results of these for the whole region indicated, for example, good overall staff support but that improvements could be made with activities and having holidays. It was therefore encouraging that this service had set up holidays for some people and was trying out different activities for people. A relative confirmed this when they said, "They are great, they ask my opinion in the yearly review. I pushed for holidays and they went." There was also analysis and plans arising from the national staff survey.

There were ways in which the quality of the service was audited. The registered manager told us of turning up at the service unannounced on occasions such as Bank Holidays, and of plans to start night-time checks. She completed a weekly service audit that covered matters such as accidents and incidents, people's looked-after monies, and medicines. Plans were recorded where shortfalls were identified. There were also monthly health and safety audits that clearly identified shortfalls. Records showed that action was taken as a result of audits.

Accident and incident records were stored on the provider's computer system. The registered manager told us this enabled direct scrutiny from senior managers and the provider's health and safety team. The records included actions taken to minimise the risk of reoccurrence, such as referrals to healthcare professionals and staff competency assessments.

We were shown quarterly reports of the provider's quality auditing team. These showed significant improvements since the registered manager started working at the service, in particular, for supporting people to undertake activities. Audits identified what worked well and where further action was needed. We met the provider's designated auditor for the service, who explained that the audits had been altered to align more closely with how we structured our reports.

The service took action where improvements were needed. Although we did not ask for it, the day after our second visit we were sent an action plan to address any concerns we had fedback. The maintenance book included records of a few matters we had identified on our first day of visiting. Some equipment that one person needed for when a community professional visited had recently run out. Whilst it was not the service's responsibility to maintain the stock, a checking system had now been set up to allow the service to alert the community professional if stock was low. Actions recommended from the provider's audit team had been taken, for example, in addressing recent fire safety risks identified. This all helped to assure that high quality care was being provided.